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LWANDA Ph.D. 2002

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POLITICS, CULTURE AND MEDICINE IN MALAWI: HISTORICAL
CONTINUITIES AND RUPTURES WITH SPECIAL REFERENCE TO

HIV/AIDS.

John Lwanda

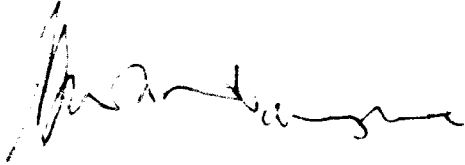
Thesis submitted for the degree of

PhD

University of Edinburgh, 2002

DECLARATION

I have composed this thesis from the results of my own work, except where stated otherwise. It has not been submitted in any previous application for a degree.

A handwritten signature in black ink, appearing to be 'M. A. Lange', written in a cursive style.

May 2002

DEDICATION

To the memory of my father 'Tiakonzere aipitse okha' William Victor Chipembere Lwanda.

To the memory of my brother-in-law and fellow music lover George Claver; and to Dr Gordon and Mrs Morag Currie for looking after us in Glasgow.

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JOHN LLOYD CHIPEMBERE LWANDA

Abstract

From reflexive, theoretical, historical and fieldwork perspectives, this multidisciplinary work (using triangulated methodological approaches) challenges and interrogates current viewpoints on health promotion, in the context of HIV/AIDS, in Malawi. The thesis is presented in a number of steps, culminating in the explication of the dynamics of cultural socialisation among primary, secondary and tertiary school students, relevant to HIV/AIDS.

First, a culturally based pre-colonial traditional framework of health promotion, medical service delivery and order maintenance is 'reconstructed', using a number of markers, which are later used to show the colonial and postcolonial persistence and continuity of this framework. Second, it is argued that this culturally based medical framework survived and minimised conflict (and epistemological and pragmatic dialogue) with colonial power and medicine by largely retreating into localities. This created localised indigenous communal medico-cultural and welfare traditions, which continued to offer services to most Africans. Third, it is suggested that the framework's postcolonial persistence reflects the limited colonial and postcolonial socio-economic change in Malawi, with elites now, as whites then, controlling limited western medical resources at the expense of the *anthu wamba* (peasantry).

Fourth, a critical history of HIV/AIDS in Malawi shows how, having entered Malawi in this context, the HIV/AIDS epidemic was bound to be viewed through these vibrant localised traditional frameworks of beliefs. The localised beliefs affected the perceptions and responses to, as well as the extent of, the epidemic; some Malawians saw HIV/AIDS as *mdulo* or *kanyela* (wasting diseases caused by transgressing sexual taboos). Fifth, political, religious and economic factors also affected the explanations and interpretations of and strategies for dealing with HIV/AIDS, contributing to a donor-dependent National Aids Strategic Framework (2000 – 2004) predicated on assumptions of socio-economic, educational and developmental progress.

Six, the fieldwork confirmed the vibrancy of and influential dynamic of indigenous culture towards health beliefs and practices among the general public, and school students in particular, despite a high level of awareness among school students (and the public) about the scientific aspects of HIV/AIDS. Seven, these high awareness levels, even in school contexts co-exist with discourses, such as *ufiti* (witchcraft), which are influenced by localised cultural traditions. Eight, it is argued that, given the socio-economic constraints, these discourses may influence or dilute western HIV/AIDS awareness messages and influence the actual socialisation and social and sexual behaviour of students.

Nine, an explication of why and how these localised cultural practices, crucial in socialisation, are, in the postcolonial era, maintained and transmitted is made among primary, secondary and tertiary school students. This explication cites the need to bridge the gap between academic knowledge and modernity on one hand and practical reality on the other, creating a coping strategy and dynamic, which utilises the most appropriate and affordable elements of both modern and traditional culture. This coping strategy and dynamic, in effect a duality permitting pragmatic construction, is here termed traditionality. The various forces – including medical, political, social, economic, and cultural - constructing and shaping this traditionality are crucial in HIV/AIDS discourse.

Ten, it is noted that postcolonial governments' exploitation of traditionality in order to maximise patrimonial control of the *anthu wamba* (peasants) and the elite share of scarce western medical resources, serves to re-enforce traditionality by promoting the protection of localised practices from postcolonial governmental gaze. It is thus a contributory factor to students' socialisation along more traditional lines.

Finally, it is suggested that, given all these contextual factors, in Malawi an effective HIV/AIDS and health promotional discourse among school students needs to take greater note of, and engage more directly with localised cultural and socio-economic realities.

TABLE OF CONTENTS

Dedication	3
Acknowledgements	4
Abstract	5
Contents	6
List of tables and figures	13
Glossary of terms and	
Abbreviations and acronyms	15

CHAPTER ONE

Background, theory and methodology	20
Chapter Methodology	20
1.1 Background to the research.	20
1.2 Research Questions	25
1.3 Justification for the research	29
1.4 Methodological Overview	32
1.5 Definitions	34
1.6 Theoretical considerations and justification for the paradigm	36
1.7 Causality, Validity and validation in Traditional medicine	45
1.8 Outline of the thesis	49
1.9 Critical assessment of my own work	52
1.10 Chapter Conclusion	53

CHAPTER TWO

Pre-colonial historical perspectives	54
2.1 Introduction	54
Chapter Methodology	54
2.2 Background	56
2.3 A brief pre-colonial cultural and political history of Malawi.	59
2.4 Sexual health and disease prevention	65

CHAPTER THREE

A survey of the socio-cultural colonial history of Malawi.	69
Chapter methodology	69
3.1.1 The terrain of early conflicts	70
3.1.2 Class, race and power	74
3.1.3 Training of traditional practitioners	79
3.1.4 Health education and dialogue	79
Medical training	81
3.1.5 Nationalism, medicine and culture	91
3.2 Aspects of colonial western medicine, education, gender and traditional culture in Malawi.	93
Gender	95
3.3 Notes on the postcolonial politico-cultural contests	98
3.3.1 The cabinet crisis	99
3.3.2 The Religious complicity	103
3.3.3 Politics and the culture of violence	104
3.3.4 The Malawi Young Pioneers and Youth Week	106
3.3.5 The Chilobwe murders	113
3.4 Chapter Conclusion.	117

CHAPTER FOUR

The history of HIV/AIDS in Malawi	120
Chapter methodology	120
4.1 What is HIV?	121
Ways of reducing HIV transmission	123
4.2 Origins	125
4.3 Names, meanings and impotence	128
4.4 Cultural Practices usable in HIV/AIDS Prevention	131
4.5 Cultural Practices Conducive to HIV Spread: a Regional Perspective	133

4.6	Activities and agendas	136
4.7	The Role of Dr Banda's Government	141
4.8	The regional context	145
4.8.1	The war in Mozambique	145
4.8.2	The Mozambique Refugees	146
4.8.3	The Malawian migrants to <i>South Africa</i>	147
	The Donors	148
4.9	The multi-party era 1994 – 2001	149
4.10	Elite Self-interest	152
4.11	<i>Mchape</i> and the return to traditional therapies ¹	154
4.12	A critique of the Malawi National Aids Control Programme (NACP) National Aids Strategic Framework (NASF) 2000 – 2004.	156
4.13	Theoretical issues pertaining to education and culture in the Malawian context	166
	Methodology	166
4.14	Current Cultural Perspectives	175
4.15	Current perspectives on HIV/AIDS	178
4.16	Chapter conclusion	181

CHAPTER FIVE

	Prevailing cultural attitudes impacting on disease causality	183
5.1.1	Chapter Methodology and Structure	183
5.2	Methodology	184
5.2.1	Fieldwork overview	185
5.2.2	Background	188
5.2.3	Aims, designs and methods	188
	Reflexivity	190
5.2.4	Modifications to the field trip	191
5.2.5	Procedure	193
5.2.6	Focus Group Discussions	195

¹ *Mchape* (the cleanser), an herbal drink.

5.2.7	Qualitative Interviews	196
5.2.8	Participant Observations of Cultural Activities	196
5.2.9	Interviews with traditional practitioners	197
5.2.10	Archival and literature searches	198
5.2.11	Press Monitoring	198
5.2.12	Radio Monitoring	198
5.2.13	Recordings	199
5.2.14	Case studies	199
5.3	Historical Continuities and awareness of study issues	200
5.3.1	Historical continuities	200
5.3.2	Awareness of issues	203
5.4	A survey of prevailing cultural practices in Malawi	205
5.4.1	<i>Literature review</i>	205
5.4.1.1	<i>A vibrant tradition</i>	205
5.4.1.2	African Traditional Religion (ATR), <i>mdulo</i> and HIV/AIDS	207
	<i>Mdulo</i> (sexual avoidance taboos): an example of a persisting communal framework of health	208
	<i>Nyau</i> : a formative social construct	212
	Causality revisited	212
5.4.1.3	Tradition, class, education and modernity	216
5.4.1.4	The role of gender	217
5.4.1.5	Family Planning	218
5.4.1.6	Non-indigenous religions	220
5.4.1.7	The value of life and fatalism	222
5.4.2	Fieldwork findings	224
5.4.2.1	A vibrant cultural tradition	224
	Traditional practitioners	225
	Daily discourse	226
5.4.2.2	African Traditional Religion, <i>mdulo</i> and AIDS	228
5.4.2.3	Traditions, class, education and modernity	229
5.4.2.4	The role of women	232
5.4.2.5	Family Planning	233
5.4.2.6	Non-indigenous religion	233

5.4.2.7 The value of life	234
5.4.3 Questionnaire results	236
5.4.3.1 Vibrant traditional medical practices	236
5.4.3.2 Family Planning and sexual health	246
5.4.3.3 Non-indigenous religions	247
5.5 Oral Discourse, music and language	248
5.5.1 Oral Discourse and language	248
5.5.2 Language	249
5.5.3 Musical Discourse	255
5.5.3.1 Themes relevant to HIV/AIDS discourse in broadcast and recorded music	255
Section Methodology	255
5.5.4 Conclusions	259
5.6 <i>Ufiti</i> (witchcraft)	260
5.6.1 Literature review	260
5.6.2 Current <i>ufiti</i> discourse	264
5.6.3 Qualitative and quantitative survey results on <i>ufiti</i>	276
5.6.4 Conclusions	282
5.7 <i>Kukhwima</i> (fortification)	285
5.7.1 Literature review	285
5.7.2 Current perspectives on <i>kukhwima</i>	286
5.7.3 Results of student surveys	286
5.7.4 Conclusion	289
5.8 Malaria	290
5.8.1 Literature review	290
5.8.2 Current perspectives on malaria	291
5.8.3 Results of student surveys	292
5.8.4 Conclusions	293
5.9 <i>Nyamakazi</i> (Rheumatism)	293

5.9.1	Literature review	293
5.9.2	Current perspectives on <i>nyamakazi</i>	294
5.9.3	Results of student surveys	295
5.9.4	Conclusions	295
5.10	HIV/AIDS	295
5.10.1	Results of student surveys	296
5.10.2	Conclusions	299
5.11	Chapter Conclusion	299

CHAPTER SIX

Localised cultural attitudes and beliefs: a model

	of socialisation	303
6.1.1	Chapter Methodology	303
6.1.2	Localised cultural attitudes and beliefs: a model of socialisation	303
6.2	Social, economic, cultural and educational imperatives	304
6.2.1	Poverty and land shortage	304
6.2.2	Unmet need	309
6.2.3	Gap between aspiration and intended reality	310
6.2.4	Strong Traditions	311
6.2.5	Limited formal educational resources	313
6.2.5.1	General education	313
6.2.5.2	Health education	316
6.2.6	The maintenance of order in a largely informal socio-economic context	320
6.2.7	Some constructive traditional cultural constructs	320
6.3	Some communal modes of socialisation	321
6.3.1	Literature review	321
6.3.2	Hybridity, socialisation and modernity	324
6.3.3	The significance of modes of communications in establishing and Reinforcing Social Norms, Attitudes and Beliefs	326
6.3.3.1	Orality	328

6.3.3.2 Music	330
6.3.4 Reinforcement via the electronic media	334
6.3.5 Death: the Ultimate socialiser	335
6.4 Conclusion: Impact of contextual cultural socialisation and discourses on health promotion messages with reference to HIV/AIDS	336
CHAPTER SEVEN	
Suggestions, implications and thesis conclusions	341
7.1 Implications and suggestions	341
7.2 Conclusion	342
Acknowledging the socio-cultural and economic context	349
Re-appraisal of what has been done so far	351
Need for a more culturally engaged and pragmatic framework for action	353
References	359
Personal Communications and Interviews	407
Appendix 1	
<i>Tikutha</i> by Dennis Phiri	409
Appendix 2	
Sources consulted	411
Appendix 3	
QUANTITATIVE QUESTIONNAIRE	413
Appendix 4	
QUALITATIVE FRAMEWORK	420

List of Tables

Table 1	National HIV Prevalence Rates for Malawi (2001)	29
Table 2	Laboratory investigations in HIV/AIDS	124
Table 3	Health care maintenance of HIV-infected individuals	125
Table 4	Sites of questionnaire surveys	192
Table 5	Students surveyed sorted according to level of education	194
Table 6	Types of Questionnaires	195
Table 7	Are you aware of rheumatism, malaria, HIV/AIDS, <i>kukhwima</i> (fortification) and <i>ufiti</i> (witchcraft)	204
Table 8	Do you believe that the following can be treated by traditional practitioners?	236
Table 9	Who first took you to a traditional medical practitioner?	238
Table 10	Statement: Traditional medicine can harm people	239
Table 11	Statement: Western medicine can harm people	241
Table 12	Do you intend to use traditional medicine in future?	242
Table 13	Do you intend to use western medicine in future?	243
Table 14	Question: What in your opinion causes illness?	245
Table 15	Question: How do you prevent HIV/AIDS?	247
Table 16	An analysis of the lyrical content of broadcast, archive and cassette music in Malawi	257
Box 1	Edited transcripts of MBC <i>Nkhani za m'maboma</i> programmes	268
Case study 1	Roadside merchandise safety	270
Case study 2	Chief Chindamba and the <i>ufiti</i> at Malindi	272
Table 17	Question: Do you think/believe that <i>ufiti</i> can cause the following: rheumatism, malaria or HIV/AIDS?	277
Table 18	Do you happen to know what witchcraft is used for?	280
Table 19	Do you think <i>kukhwima</i> protects from rheumatism, malaria, HIV/AIDS or <i>ufiti</i> ?	288
Table 20	Question: Question: Would you think of using fortification yourself?	289

Table 21	Do you happen to know what causes HIV/AIDS?	296
Table 22	How do you prevent HIV/AIDS?	297
Table 23	Total population 1901 – 1988 Censuses	305
Table 24	Who first took you to a traditional practitioner?	322

Glossary of terms

Achikulire – (in the context of political and economic power), the neo-patrimonials, the business and high civil service elite, who dominate Malawi urban, (and from the economic perspective, rural) society. In rural culture, *achikulire* refers to society elders and leaders.

ADMARC – Agricultural Development and Marketing Corporation.

Afiti – Witches.

AFORD – Alliance For Democracy.

AIDS – Acquired Immune Deficiency Syndrome.

Amasiku ano – the modern ones.

Anankungwi - rites of passage guardians and practitioners.

Anthu wamba – lit. ordinary folk, the peasantry.

ATR – African Traditional Religion. This concept is used in line with the term's use by the Chancellor College Department of Religious Studies.

Azamba – traditional birth attendants.

CADOC – Coatbridge and Aidrie Doctors on Call.

CBOs - community based (voluntary) organizations.

CC - Cabinet Crisis.

CCAM – Chitutuko Cha Amai m'Malawi.

CCAP – Church of Central African Presbyterian.

CDC – Centres for Disease Control, Atlanta, USA.

CDP – Christian Democratic Party.

CHAM - Christian Health Association of Malawi.

Chauta – God (Chewa).

Chinamwali – puberty initiation rite for girls among the Chewa.

Chiputu – pre-colonial Yao puberty initiation rite for girls.

Chiriza – a post funeral Nyanja/Chewa rite.

Chirombo – wild beast.

Chithumwa – A small pillow or sachet shaped medicine-containing charm. A *chithumwa* is protective.

Chiwerewere - diseases arising from promiscuity, like syphilis and gonorrhoea.

Co-morbidity – the presence of other disease or diseases other than the index disease.

CSR – Centre for Social Research, University of Malawi.

DANIDA – Danish International Development Agency.

DevPol – Development Policy.

DFID – (United Kingdom) Department for International Development.

Edzi – AIDS.

EFA – Education for all.

Eni dziko - the owners of the village or land.

EU - European Union.

Fisi – lit. hyena. A man who, anonymously and at night, performs ritual sex with an initiate at the end of her initiation or with a woman whose husband is infertile.

Gule wa mkulu – the big [sacred] dance.

HIV – Human Immunodeficiency Virus.

HSRC – Health Sciences Research Committee.

ILAM – International Library of African Music.

IMF – International Monetary Fund.

Jando – Yao Muslim pubertal initiation rite for boys, which includes circumcision.

Kachirombo – diminutive of *chirombo* (beast).

Kanyela – a wasting disease arising from having adulterous sex with a menstruating woman.

KCN - Kamuzu College of Nursing.

Kudula – lit. to cut. The act of causing illness or ill health through transgressing a sexual taboo.

Kukhwima – Fortification.

Kulodza - to bewitch.

Lupanda – pre-colonial Yao pubertal initiation rite for boys.

Malawiana – Malawi section of Chancellor College Library.

Maliro – funeral.

Malungo – Malaria.

Mankhwala – medicine.

MANEB – Malawi National Examinations Board.

MASAF – Malawi Social Action Fund.

MBC - Malawi Broadcasting Corporation.

Mbumba – political party (particularly Malawi Congress Party of 1958 – 1994) women who compose or appropriate traditional songs and sing them in praise of political

leaders.

Mchape - The cleanser, an herbal drink designed to prevent or heal diseases. *Mchape* can also be used in witch finding.

MCP – Malawi Congress Party.

Mchape – a cleansing herbal drink. (Lit. something that or some one who washes).

Mchape was the name given to witch finders during the colonial and post-colonial era.

MDHS – Malawi Demographic Health Survey.

Mdulo – a system of beliefs and practices guiding the care of children and sexual relations among adults, transgression of which can lead to *mdulo* diseases.

Mfiti – witch.

MKAP - Malawi Knowledge Attitudes Practices Health Survey.

Mlandu – a charge, case or act of being sued after breaking traditional/customary law.

MNA –Malawi National Archives.

MNFPS – Malawi National Family Planning Survey.

MOESC – Ministry of Education, Sports and Culture.

MOH – Ministry of Health.

Moyo – life. Also means health.

Moyo wa masiku ano - today's culture, mores.

Mphinjiri - a medicine that protects from misfortune.

Mtsiliko – protection against sorcery.

Mwabvi – poison used in witch finding ordeals.

Mwambo - custom.

Mwambo wathu – Our culture.

Mwini wa dziko – owner of the land.

MYP – Malawi Young Pioneers.

NACP – National AIDS Control Programme.

NASF - National AIDS Strategic Framework.

Nankungwi – woman in charge of initiation and other rites (of passage).

NEPAD – New Partnership for African Development.

NGO – Non-Governmental Organisation.

Njirisi - a protective charm.

NPDP - Nyasaland Protectorate Development Programme.

Nsembe – sacrificial offering.

NSO – National Statistical Office.

Nsondo – Yao Muslim initiation rite.

Nsupa or *supa* – a small gourd containing either offensive or protective/curative medicine. *Nsupa* can be used by both *afiti* or *asing'anga*.

Nyau – a religious, cultural and social secret organization among the Chewa, through which intercession with *mizimu* (ancestral spirits) to *Chauta* (God) is made. The *gule wamkulu* (big dance) symbolizes the spirit world. The *nyau* movement has religious functions at initiation, funerals and serves as a vehicle for social cohesion.

Nyamakazi – (lit. female flesh) Rheumatism.

Postcolonial – after independence (in July 1964). This term is preferred to post-independence because of the similarities of the Banda and colonial regimes.

Post-colonial - denoting discourses informed by epistemologies and psychological orientations of the postcolony.

PSI – Population Services Incorporated.

Sadaka – a post funeral Islamic rite (Cf. Christian memorial service).

SARDC – Southern African Regional Development Council.

Sing'anga – a traditional medical practitioner or magician. Pl. *asing'anga*. Most *asing'anga* offer protective, diagnostic and curative services and are not involved in witchcraft. Witchcraft is the province of corrupt *asing'anga* or *afiti* (witchdoctors).

SPU – Malawi Government's Strategic Planning Unit. The Vice-President heads this.

STD – Sexually Transmitted Diseases. Also known as Sexually Transmitted Infections – (STIs). The most common STDs in Malawi are: Gonorrhoea, syphilis, chancroid, Hepatitis B and C, and HIV/AIDS.

Thangatha - indentured labour. *Thangatha* has in the post-Banda era, like *Theba* (after The Employment Bureau for Africans) come to signify heavy 'almost slave like work for minimal wages'.

Traditionality – (Cf. modernity) the concept of appropriate rather than necessarily backward traditional systems coping with reality. This is a construct based on traditional concepts and/or responses of the *anthu wamba* to, and interactions with, modernity.

Tsempho – disease in a newly born child arising from parental failure to undergo the *kutenga mwana* sexual cleansing ritual. Prior to *kutenga*, in orthodox contexts, only the mother and grandmother are allowed to handle the baby.

Tsoka – misfortune.

UDF – United Democratic Front.

Ufiti - Witchcraft or sorcery. Also called *masalamusi* (Tonga) and *usawi* (Yao).

Ufiti discourse refers to the use of or implication of or metaphorical use of *Ufiti*, both in serious and light-hearted conversation, by believers and non-believers. The latter use references to *ufiti* or the possession of *ufiti* powers in a friendly, benign and jocular manner, the former use *ufiti* discourse in earnest. Politicians and other cultural-restorative groups may appropriate *ufiti* discourse.

Umunthu – humanity.

UNDP – United Nations Development Programme.

UNAIDS - Joint United Nations AIDS Programme.

UNESCO – United Nations Educational, Scientific and Cultural Organization.

UNFPA – United Nations Fund For Population Activities.

UNICEF – United Nations’ Children’s Educational Fund.

UNIMA – University of Malawi.

UN IRIN – United Nations Intergrated Regional Information Networks.

Unyago – initiation.

USAID - United States’ Agency for International Development.

Virombo, *Vimbuza* and *Vyanusi* - Various degrees of spirit possession diseases, with *virombo* being the mildest and *vyanusi* the most severe.

Vuma – Strong east to west winter winds on Lake Malawi in winter (June – August).

Weni weni – The real ones.

CHAPTER ONE

BACKGROUND, THEORY AND METHODOLOGY

Chapter methodology

In this Chapter I utilise reflexivity (Hammersley and Atkinson, 1983) to outline my background, theoretical framework, values and other personal factors that may impact on the study. This reflexive element is intended to give the context – and hence the methods chosen - within which the study is located.

1.1 Background to the research.

A number of seemingly unconnected events stimulated my interest in the following work. These include: the magnitude of the HIV epidemic,² the palpable resurgence of traditional culture during the political transition of 1991 - 1994,³ my experiences as a medical specialist at the Kamuzu (Lilongwe) and Queen Elizabeth (Blantyre) Central Hospitals, my own socio-political experiences and, finally, my interactions, after a twenty three year absence, with my family.⁴

Malawi, a small country of 119,000 square kilometres and a population of 9,933,868 (National Statistical Office, 2000a and 2000b), was from 1891, until independence in 1964, a British protectorate. 34 years after independence, Malawi's poverty and health indices place it among the poorest countries in Africa (World Bank, 1995: 23 - 53). It is a designated United Nations Least Developed Country with real earnings and per capita

² The HIV epidemic was responsible for 33% of all admissions to the medical wards of Lilongwe Central Hospital in 1994 (Lwanda, 1995). Some antenatal clinics in Blantyre and Mulanje are reporting that one in three of pregnant women attending their clinics are HIV positive.

³ Aspects of culture were utilised by both sides in the transition from one party to multi-party rule (Cf. Lwanda, 1993; Kaspin, 1993; Forster, 1994). This palpable resurgence was a manifestation of civil society's release from repressive laws and strictures, a release that freed capital (economic) and cultural activities.

⁴ I had been away from Malawi for educational (1970 – 1979) and political reasons (1981 – 1993). I was involved in proto-United Democratic Front (UDF) (1991 – 1993) and UDF (1993 – 1994) politics, becoming one of the first ideological dissenters on 5 June 1994, when I left the UDF and returned to full time medicine. I had returned to Malawi on 25/5/94 as the UDF 'shadow deputy health secretary'.

recurrent expenditure on Health and Social services falling since 1991 (Britannica data, 1998: 653; UNDP/Malawi Government (Ng'ombe and Mawaya (Eds) *Malawi Vision 2020* draft report, 1997). It has an infant mortality rate of 123.4 per 1000 births (Britannica, 2001: 665) and the commonest causes of death and disease are still preventable: pneumonia, measles, malnutrition, diarrhoea and AIDS (Cf. Ng'ombe and Mawaya, 1997; Malawi Government, 1989; Reeve and Wirima 1988; Lwanda 1995; and Zigona 1996). To compound this, the educational system has remained inadequate (Malawi Government *Development Policies (DevPol) 1987 - 1996*, 1987: 104 -111). It is also one of the countries most affected by the HIV/AIDS epidemic (Malawi National Aids Control Programme Sentinel Survey reports, 1999, 2000).

A sudden, and early, exit from politics at the beginning of a sabbatical period gave me some unplanned free time.⁵ I used some of this time to conduct and, at times, drive my brother's minibus. This activity brought me close to working class or peasant peri-urban culture in Malawi and gave me cultural insights that I would never have obtained had I exclusively remained in elite professional or political culture.

The teeming markets of Lilongwe, Zomba and Blantyre are the usual termini for the minibuses. In these environments my interest in the subject of rural Malawi culture and,

⁵ The battles for human rights and multiparty rule of 1991 – 1993 brought together many disparate groups opposed to Dr Banda under the banner of the United Democratic Front. The second phase of the development of the UDF, between 1993 and 1994, was characterised by the exclusion of many new politicians, including professionals and intellectuals from the UDF ranks as the business section of the UDF assumed dominance. Bakili Muluzi, a former Secretary General of the Malawi Congress Party and businessman had, from early 1992, led a coalition of businessmen, small traders, hawkers, academics, former dissidents and intellectuals opposed to Banda during the transition. This coalition of disparate interest groups was a compromise and metamorphosed into the United Democratic Front. The business elements quickly gained ascendancy (Lwanda, 1996: 86 - 187) and, on achieving power, sidelined most of the intellectuals and new politicians. Thereafter the UDF came to be dominated by the small and big business elements that had been marginalized by Dr Banda. As this group had to quickly build up their financial power bases in order to secure their patronage bases, the first three years of the UDF rule was dominated by two imperatives: a) the accumulative urges of Muluzi's business group and b) the need to remove or co-opt Banda's former patronage base, now led by his long time associate, John Tembo. Against this background, civil servants, though now freed from Banda's constraints, found ministers more 'interested in business than policy' (Cf. Dowd, 2001). By 1998, the absence of a de-autocratisation agenda (Mapanje: 1995: 14) and the rise in *achikulire* (neo-patrimonial) politics (Lwanda, 1996: 17 – 37) had become established (Phiri, K. and Ross, K. R, 1998) and the business group's domination of the UDF was total, leading to the marginalisation of once powerful residual new politicians like Cassim Chilumpha and Brown Mpinganjira. Of relevance to this work is the fact that, as many of the residual new politicians died, many due to HIV/AIDS (according to Sam Mpasu the Malawi Parliament Speaker in 1999), the UDF came to be dominated by people previously in the MCP (Cf. Interview with Brown Mpinganjira, *The Lamp*, June 2001) whose health policies did not priorities HIV/AIDS.

specifically, *ufiti* (witchcraft) was further stimulated, because of the ubiquity of *ufiti* discourse.⁶ The markets are the hubs of Malawi's dominant informal sector and where the orally driven public sphere has one of its main feeding points.⁷ The discourse of the market place is rich, not only in economic language but also in proverbs and other social discourse.⁸ It is a rich source of political, socio-medical and social insights. The contradictory degree of rivalry and camaraderie is set against a background of the need for collective order among the apparent chaos. Crucial in these market and minibuses environments was the need for security: goods sometimes need to be left when the owner goes to the toilet or even in the market overnight. And bus conductors need their takings protected from thieves.

The year 1994 was a period of transition from the authoritarian regime of Dr Banda to a multiparty regime. As the certainty and clearly defined limits and constraints of the one party era crumbled, and Dr Banda's paramilitaries disappeared from the road blocks and markets, the new found civil liberties were, sometimes understandably, abused and severely tested (Lwanda, 1996; Phiri, K and Ross, K. R., 1998). The 'orderly' Malawi was replaced by a Malawi where crime soared, hawkers traded where they felt like and a *laissez faire* business environment emerged (Chirwa and Kanyongolo, 2000).⁹ Where Dr Banda's legal and informal enforcers had operated, a vacuum seems to have been created. The soaring crime led to increasing instances of summary mob justice - both fatal and non-fatal, as criminals were beaten up or set on fire.¹⁰ But beatings, while deterrents, were not preventive. In comparison, the rural areas appeared comparatively free of this turmoil. This security conundrum puzzled me. Having fought for it, I

⁶ I conducted and drove minibuses on the Lilongwe-Blantyre, Lilongwe-Zomba, Zomba-Blantyre, Lilongwe-Salima and Lilongwe-Mangochi routes. Here, *ufiti* discourse (see glossary) refers to both the serious and light-hearted variety; in the latter references to *ufiti* or the possession of *ufiti* powers are made in a friendly benign and jocular manner. See Chapter Five (5.2.1).

⁷ The concept of an orally driven public sphere (Cf. Habermas, 1989) is developed in chapter six of this thesis.

⁸ Proverbs play a significant part both in the socialisation process and daily social discourse in Malawi (Cf. Chakanza, 2000).

⁹ Hawkers, charcoal burners and other informal sector traders were influential in undermining Dr Banda's rule of law when, encouraged by the anti-Banda pressure groups - the United Democratic Front (UDF) and the Alliance for Democracy (AFORD) - but resented by most Asian businessmen, they began flouting city rules, from 1992 onwards by trading 'anywhere'. On attaining power, in 1994, the former pressure groups, now in a ruling coalition, found it difficult to 'control' the chaotic business. Paradoxically, by this time a significant section of Asian businessmen now controlled some of the hawkers and had, by 1994, achieved a degree of compromise with the UDF.

¹⁰ Widely covered in issues of *The Nation*, *Daily Times* of 1993 - 1996.

nevertheless felt generally threatened by the post-Banda freedom that a multi-party environment “granted” the lawbreakers. At the same time, I felt personally very safe in my working environment, protected, as I was, by these informal but firm conventions of ostracisation, beatings or even “necklace burning” of transgressors by the collective.

These anti-crime measures were not, in themselves adequate in the context of a mixed economy. In some contexts, *ufiti* discourse seemed to provide a better answer. The discourses of *ufiti* and the apparent resurgence in the popularity of traditional medicine were later bolstered by the arrival of the traditional healer Chisupe, in 1994. His *mchape* (a cleansing herbal drink) remedy is a signifying feature of the period.¹¹

My quest for answers to the “security” question intensified. This was partly prompted by the fact that I was living, at least for large parts of my day, at what could be termed as the frontline between institutional and informal order. Institutional in the sense that, like hawkers and other informal traders, minibuses operators are subject to some of the most frequent encounters with formal agencies of governance: police checks, road safety inspections and Custom Department spot checks. Informal in the sense that these formal agencies would only offer intermittent security; taking the country as a whole informal structures being, by and large, responsible for security.¹² How is urban security, in a more liberal multiparty environment maintained? How is the traditional village security culture, away from the teeming and oppressive colonial and postcolonial law and order constructs, maintained?¹³ The construction of this order appeared relevant and increasingly significantly related to the construction of a socio-

¹¹ Chisupe claimed that his herbal drink could cure and/or prevent HIV/AIDS. Chisupe and his *mchape* are discussed in Chapter Four.

¹² In 2000, the Malawi Roads Authority came into being and had to raise its own revenue via a fuel duty levy and the Malawi Police were, from then, allowed to retain all the earnings from road fines for their budget. Prior to 2000, many rogue policemen operated informal roadblocks and harassed minibus drivers for bribes; after 2000, more roadblocks appeared as the Police Department attempted to maximise its income.

¹³ Until armed criminal gangs started terrorising them, in 1995- 1996, rural areas – shorn of Banda’s oppressive youth leaguers, had enjoyed a brief period of genuine ‘peace and order’.

I am grateful to Jack Thompson and Jack Mapanje for drawing my attention to the debates surrounding the ‘postcolonial’, ‘post-colonial’, ‘postcolony’ and other related and contested terms and concepts. Here postcolonial is preferred to post-independence because of the complex nature of Dr Banda’s regime (which exhibited imperial, neo-colonial and sovereign features) and the donor-dependency of the post-Banda governance. In this work Postcolonial refers to “after independence (in July 1964)”; and Post-colonial - denotes ‘discourses informed by epistemologies and psychological orientations of the postcolony’.

medical order, as Chisupe and his *mchape* was later to show (Cf. Lwanda, 1996: 283 – 284; Probst, 1999: 109 - 137; Schoffeleers, 1999: 406 - 441).

The change from one-party to multi-party rule had after all been inspired, in large measure, by hunger, poverty and disease (Cf. Roe et al, 1989; Roe, 1992; Msukwa, 1994). The urban hospitals were under-funded and under-resourced. Those in the rural areas were even in worse states. And yet there were no health service protests comparable to those of 1964, when Dr Banda's postcolonial government had proposed health charges (Cf. Short, 1974: 199).¹⁴ Although, as I soon discovered, it was difficult for medical and nursing personnel to work in an under-resourced environment, it was even more difficult for the patients.¹⁵ Yet the political responses to the epidemic and to health in general appeared inadequate compared to the initiatives in, and priorities accorded to, other sectors.¹⁶ However, in 1994, complaints against the inadequacies of the health system were few. It appeared as if the unfolding HIV/AIDS tragedy and government medical service deficiencies were being borne with an apparent quiet acceptance.

I therefore wondered if the patients, in the post-Banda democratic environment of 1994 - 1995, who seemed happy to use both traditional and western medical systems, were doing it out of want, need or necessity? I experienced this medical duality¹⁷ at first hand when some of my patients, both in the paying (elites) and non-paying wards, at Lilongwe Central Hospital, in 1994, would be taken out from the wards at weekends to consult traditional healers, returning in time for my next visit (Lwanda, 1995). The reasons for this, it appeared to me, needed some clarification. As far as I was aware the dual use of both western and traditional medicine had not been studied to any great extent in Malawi. A literature search confirmed this fact. The *Bibliography of Health information in Malawi*, compiled by the Research Unit of the Ministry of Health, covering the period 1980-1991 (Ministry of Health, 1991c), for example, contains only 14 entries relevant to traditional medicine - out of 682 entries. The Centre for Social

¹⁴ This episode, part of the 'Cabinet Crisis' of 1964, is discussed in more detail in Chapter Three.

¹⁵ Patients, for example, often shared beds, had no access to antibiotics or painkillers and often waited for days before seeing, if at all, medical specialists.

¹⁶ Like the expensive presidential palaces and state houses, contrary to pre-election UDF policy.

¹⁷ Here as the existence of two distinct and parallel systems which are nevertheless accessed simultaneously or at different times by the same or different sectors of the population.

Research's directory, *Two decades of Social Research: a directory, 1979 – 1999*, did not contain any entries on traditional medicine; the references to culture were only found in the HIV papers. Yet the traditional medicine sector provides up to 80% of the health care in Malawi (Msukwa, 1981; Malawi Ministry of Health, 1983; Peltzer, 1986; Msonthi, 1986; and Ndibwani et al., 1998).

These personal observations, anecdotal evidence and paucity of research evidence suggested that there was a need to quantify, contrast and qualify the use of traditional medicine by elites and rural dwellers. I was particularly struck by the fact that some elites used scarce resources on seeking both traditional and orthodox medical cures for HIV related diseases. The dual use of traditional and western medicine by elites, including some recently returned Diaspora Malawians, despite their western education particularly intrigued me.¹⁸ Further, the degree of inequity in the availability of health resources to the various socio-economic groups soon became clearer. A few of the elite would be flown to South Africa for treatment of HIV-related illnesses when basic amenities and resources were lacking in hospitals. And yet, despite the presence of freedom of speech, few complaints were recorded.

1.2 Research Questions.

It seemed to me that a dynamic relationship between politics,¹⁹ medicine and culture exists in post independence Malawi. It also appeared to me that political considerations determined the degree of service provision, regardless of need.²⁰ But I wondered how this was possible in the context of a free dispensation. The ability to contain unmet needs appeared to me, to be related, to an extent, to the ability with which socio-cultural factors could be used to contain these unmet needs. And, given the new democratic dispensation, these socio-economic factors would have to be used more effectively than Dr Banda managed.

My interest in this relationship between culture, politics and medicine intensified when

¹⁸ In the wake of the 1993 vote for multi-party rule, many exiled Malawians returned from South Africa, Zambia, East Africa and the United States of America.

¹⁹ Here 'politics' as the 'power and disposer' of governance and economic resources.

²⁰ This aspect is explored in Chapter Three.

I began studying the HIV epidemic in Malawi, initially the nutritional aspects (Lwanda, 1998: 89).²¹ As I experienced the HIV/AIDS discourse, I found that the largely western-oriented preventative messages of abstinence, condoms, HIV tests, and self-empowerment were often in stark contrast to the reality of poverty, thriving 'cultural practices' and a majority population minimally served by government western medicine and its health promotion services. The apparent lack of political urgency in the health sector, once power had changed hands, was particularly striking. Scarce resources were directed to other politically determined sectors. The western medical services were, it appeared, not delivering the preventative services required to contain the HIV/AIDS epidemic. However, even the elite who were able to benefit from the scarce western medical services were still as susceptible, if not more so in some cases (Dallabetta et al, 1991), than those who depended largely on traditional medical services. The issue of HIV/AIDS containment could therefore not be reduced to that of the availability of western medical resources.

Further, I noted that the attitudes towards HIV/AIDS and western medicine emanating from some of the educated young people I interacted with appeared to be informed more by 'traditional culture' than western health promotion concepts. As a 'recovering'²² political activist I had a number of intense political, social and cultural debates with some of these young Malawians in the period 1994 – 1995; debates stimulated by the rapid and dynamic events surrounding the political transition. I will, here, summarise the young activists' phased arguments.

First phase (as heard from 1993 – early 1994): We, the youth of Malawi, are confident that, after the elections we will get rid of these corrupt ex-MCP *achikulire*, and all those old people who have failed this country, and bring in a fresh, dynamic and development oriented leadership.²³

²¹ I was struck by the fact that both urban and rural poor tended to bring their hospitalised relatives Fanta orange drinks, rather than the more nutritious *Mahewu*. In rural contexts the food (maize flour, cassava and, less often, rice) seemed more appropriate.

²² Used in the Alcoholics Anonymous sense that 'once an alcoholic, always an alcoholic' but one could, nevertheless, regard oneself as being on a continuing process of recovery from alcoholism.

²³ Incidentally, the same sentiments expressed by younger nationalists, between 1958 and 1964, about Dr Banda. They had put him up as a uniting senior figure to lead them to independence, a leader they intended to dispose of later because of his age and conservatism (Cf. Chipembere, 2002).

Second phase (May 1994 – May 1995): As the old politicians consolidate power, a palpable sense of frustration and powerlessness seems to affect many of the young political activists. Some begin to realise the importance of networks, planning and money in the political process, while, of more relevance to this study, a number begin to suggest that *Madalawa ambiri ndi okhwima* (Many of these old politicians have undergone fortification and have supernatural powers).

Third Phase (June 1995 – November 1997): Frustrated and resigned, many of the young politicians and activists split into different groups or became absorbed by the existing political parties. During the 1995 to 1999 period, many of the new politicians are ‘bought’ by the big parties.²⁴ However, it is the high number of deaths from HIV/AIDS and other diseases, like malaria (Cf. Lwanda, 1995, King and King, 2000: 76 – 84), for instance, that produced an interesting reaction. As each potential young ‘leader’ died the reaction was sometimes to blame this on ‘elimination’, *atimaliza* (they will finish us off), *tikutha* (we are perishing) and other explanations that resorted to *ufiti* or physical political elimination. Most of these explanations, in the context of the young political groups, blamed the old guard.²⁵ Thus, although HIV/AIDS appeared, from a medical perspective, to be a major cause, these young educated elites sought alternative explanations.

Fourth phase (1999): The last attempt by the youth (new politicians under 35 years of age)²⁶ to form a political party ended in chaos as some party leaders were once again co-opted by larger parties. A belief that to become a successful politician one had to undergo *kukhwima* (fortification) appeared to have been bolstered. The underlying theme here was that, as some of the prominent political leaders were famous for their alleged promiscuity; this *kukhwima* had some protective powers from sexual diseases.²⁷

²⁴ Being bought involved being given a job, a diplomatic posting, or a sizeable sum of cash. See various issues of the *Democrat*, *Nation*, *Daily Times* and *Independent* of between June 1994 and November 1997 for ‘fluidity of personnel’ among various parties.

²⁵ There were rational reasons for this: the Malawi Congress Party under Dr Banda had acquired a reputation for the ‘accidentalisation’ (killing through staged accidents) of opponents.

²⁶ This was the criterion of the Youth Party itself. Those ‘thought sympathetic’ (sic) to their agenda, like allegedly, the present writer, were to be asked for advice from time to time but would not qualify as members (Personal communication with Bisika, November 1997, July 2000). Cf. Chirambo (2000: 1 – 9) for a discussion of political aspects of musical discourse.

²⁷ See for example ‘JZU (MCP politician John Tembo) on AIDS Drug’ (*Weekly Time*, November 18 – 24, 1998, Vol. 1, 14, page 1; and the intense discussions of Muluzi’s polygamy in the Malawian press

These debates came at a time when I was retreating into medicine and the HIV/AIDS pandemic was reaching an intensity previously unimagined, in terms of statistically determined prevalence, resource consumption and subjective public awareness.

This mixture of politics, medicine, *ufiti* discourse and, at a phenomenological level, the undoubted ravages of HIV/AIDS fascinated and bewildered me.

I then began to wonder how indigenous Malawians going through formal education acquire or are exposed to traditional medical practices, skills and beliefs. I also wondered how these practices and beliefs influence their subsequent medical choices; and to what extent western formal education affected, or abolished, these beliefs.

As I continued thinking about these multiple variables, the work became focused on how this dynamic between politics, culture and medicine, has evolved, is maintained and continues to evolve. I was also particularly anxious to learn how, if at all, this dynamic has informed the HIV epidemic. It became my aim to critically study, from both historical (Marwick 1970: 17) and fieldwork perspectives this presumed interaction between culture, medicine and politics at phenomenological and epistemological levels.

I finally decided to study how this postulated dynamic between politics, culture and medicine has been and is (i) constructed and (ii) maintained to inform contemporary medical beliefs, attitudes and behaviour particularly among Malawians aged between 10 and 25, towards medicine, with special reference to the HIV/AIDS epidemic. The experimental hypothesis being that this unresolved dynamic between politics, culture and medicine has contributed and continues to contribute to the magnitude of the HIV/AIDS epidemic in Malawi.

and on *Nyasanet* (1997 – 2002). See also the references to the perceived general promiscuity of the powerful, for example: 'Mayinga in Sex scandal' *The New Vision*, 1, 3, 6th February 1997, page 1, where the issue of Peter Kalilombe's alleged affair with a school girl is also re-aired.

1.3 Justification for the research

The main justification for this research was the magnitude of the HIV/AIDS epidemic in Malawi.

The 1999, the year this study began, Sentinel Survey report (NACP, 1999: 21), for example, concluded that the estimated crude national HIV prevalence rate was 8.8 per cent (2.2 per cent among the under 15s, 16.4 per cent among the 15 - 49 age group and 1.1 per cent for those over 50); among pregnant women, HIV seropositivity rates varied from 2.9 per cent at a rural antenatal clinic at Kamboni in Kasungu to 35.5 per cent at the peri-urban Mulanje Mission Hospital.

In May 2001, the NACP estimated that the national HIV prevalence rates for Malawi for 2001 were those in Table 1:

TABLE 1.
National HIV Prevalence Rates for Malawi (2001)

National adult (15 – 49 years)	15%
Number of infected adults	739,000
Urban adult prevalence	25%
Rural adult prevalence	13%
Number of infected rural adults	516,000
Number of infected urban adults	223,000
Number of infected children	65,000
Number of infected over age 50	41,000
Total HIV positive population	845,000
(NACP, 2001: 13)	

These figures placed Malawi among the ‘worst affected’ countries in Africa (and the

world). This has an impact, which is further reducing the socio-economic base of Malawi by reducing the labour supply, productivity (especially in agriculture), reducing imports and increasing imports (Dixon et al., 2002: 232), while increasing medical overheads. These have the compound effect of debilitating and making the Malawian economy even more dependent on donor aid.

I felt that there was, building on earlier work, need for more research that tried to identify and explicate the cultural factors that contribute to HIV spread. While it had been observed and noted that certain cultural practices contribute to HIV spread, I wanted to deepen an understanding of the underlying process.

The second justification was my observation between 1993 and 1998 that there was a discrepancy between the proposed solutions and the cultural and socio-economic realities on the ground, particularly in the rural areas; the solutions being proposed to deal with the HIV/AIDS epidemic appeared more appropriate for those who live in the urban areas.

Third, a literature review had shown that little work had been done on why cultural attitudes persist and thrive even among those who have received western education. As some of my educated HIV/AIDS patients were accessing traditional medicine also I felt that this was important and worth studying in relation to the HIV/AIDS epidemic.

The Malawi Government's National AIDS Strategic Framework (NASF) is the authoritative document on HIV/AIDS initiatives by the Malawi government. The NASF drafting process involved the consulting of all relevant and available work on HIV/AIDS in Malawi. However, an examination of the earlier drafts and final versions of this document suggested that there was need for further research into other broader aspects of HIV/AIDS in Malawi. Some of the NASF's crucial objectives and strategies, while acknowledging and noting them, ultimately ignore the socio-economic and cultural realities.

My study therefore hoped to build on the base provided by the NASF and other works by further contributing towards the search for an understanding of the role that culture

plays in people's perceptions and beliefs towards both western and traditional medicine in Malawi. This, I hoped, would contribute towards the epistemologies of health planning and provision. I also hoped that this better understanding would give insights into whether 'medical behaviour' and 'choices' were pragmatic or resulted from beliefs.

The hypothesised relationship between traditional culture and western medicine, and how it informs choices and decision making in the health sector, may be one of the factors constraining the development of both curative and preventive health services in Malawi. Most of the explanations for the deficiencies in government health service provision have tended to be confined to the question of resource availability and allocation - with political priority skewing and the IMF imposed Structural Adjustment programme taking most blame (Mhone 1992: 126). My initial impression was that an integrated health system that, given the cultural environment, values both traditions would be better at achieving sustainable health promotion and prevention. A better understanding of the political/cultural/medical dynamic may advance the epistemologies of health planning, promotion and provision. The tragic history of the HIV and AIDS epidemic, described in Chapter Four, demonstrates this great need.

It has been said that contextual factors, whether social or economic and global, help in understanding the HIV epidemic (Zwi, 1993; Sanders and Sambo, 1991). This work highlights some of the contextual factors.

Above all, there is a danger that HIV infection may assume a pattern in which the most vulnerable 14 – 25 age group becomes most susceptible (Cf. Baylies, 2001; UNAIDS, 2000), becoming infected as soon as they become sexually active. This would lead, in the median term, to HIV/AIDS becoming a continuing and socio-economically debilitating chronic epidemic. In the context of a poor nation, unable to satisfactorily afford the 'condom model of prevention', cultural interventions may be more sustainable. After all, as Mazrui (1990: 7 – 8) states, culture 'provides lenses for perception and cognition, motives for human behaviour, criteria of evaluation, a basis for an identity, a mode of communication, a basis for stratification and the system of production and consumption'.

As to the need for studying traditional medicine, this is easy to justify. In Malawi, given the socio-economic context, we can predict that both medical traditions will continue to co-exist in parallel (duality) with some hybridity occurring in the middle.

1.4 Methodological Overview

As this work investigates the dynamic between medicine, culture and politics it is located in a multi-disciplinary terrain. A mixed methods research design acknowledging the inter-disciplinary nature of the work has been therefore thought appropriate. Utilising the methodological eclecticism of triangulation (Cormack, 1996), which involves ‘theoretical and methodological triangulation (Denzin, 1970) and ‘promotes more complex research designs’ (Fielding, 2001: 14) the work has a number of components:

- The historical perspective utilising archival, contemporary academic, multi-media and oral sources.
- The qualitative components, including participant observation, oral interviews, qualitative surveys, focus group discussions and the use of archival and contemporary written and recorded data, and the
- Quantitative aspects, which include questionnaires and quantitative examination of broadcast (oral and musical) and written sources.

Kelle (2001) argues that triangulation should be understood at several levels: ‘triangulation as mutual validation of methods chosen; triangulation as the integration of different perspectives on the investigated phenomena; and, finally, triangulation in its original trigonometrical meaning’. This study exploits all three meanings, as well as aspects of sequencing and other hybrid approaches (Fielding et al., 2001: 10).²⁸ Kleining et al (2001: 19) argued that

Exploration as a basic methodology of qualitative *as well as* [original

²⁸ In utilising qualitative and quantitative methods in the same study in phases or combinations.

emphasis] quantitative psychological and social research would narrow the gap between different approaches and methodologies in both disciplines and reduce the tendency to divide its methodologies into behaviouristic, deductive, “quantitative” activities on one hand and interpretative “qualitative” approaches on the other.

This theme of discovery is pursued in the quest to discover the contents of the public sphere, music lyrics and oral discourse.

Further, the inherent contradictory results that triangulation may produce can be, in the case of investigations of *ufiti* (witchcraft) beliefs, helpful in highlighting the multiple, constructed or otherwise, realities (See Chapter Five). For example the use of quantitative inquiry in Chapter Five will challenge the view that *ufiti* beliefs are universally high even among school students, in this case no such simple congruency was found between the qualitative assumptions and the quantitative data (Cf. Sieber, 1979).

The methodology approaches both culture and politics as dynamic phenomena, amenable to qualitative and quantitative study and which may impact on personal and 'national' health. In the Malawian context, Forster (1994: 489-492), Phiri (1998: 151-167) and others have pointed to the relationship between culture and national politics in Malawi. And Bernard Hours (1986: 41) asserts that 'African medicine is concerned with power'. The thrust of the study is therefore not merely to re-visit known findings from a hermeneutic approach, but to also utilize these triangulated methods in a more heuristic manner (Kleining et al, 2001: 4 – 7 and 19).

In the present work I wanted to discover the meanings and intentions in some of the discourse. To achieve as near holistic an understanding as possible a part/whole methodology was used in Chapters Five and Six. By breaking down the multi-disciplinary components each could be explicated and then referred and fitted into the whole.

The conceptual framework involves demonstrating historical continuities between the pre-colonial, colonial and postcolonial socio-cultural environments in chapters Two,

Three, Four and Five. In Chapters Three and Four, the influence of prevailing governance on traditional and western medical services' use by the indigenous population is explored. Chapter Four is a historical analysis of the HIV/AIDS epidemic in the context of the socio-economic and political environment. Chapter Five employs historical, qualitative and quantitative methods to illustrate the findings from my fieldwork: the cultural attitudes - which influence attitudes to traditional and western medicine and HIV/AIDS - could be shown as still significantly influenced by traditional attitudes and practices.

In Chapter Six, a modeling concept is used to suggest a process of communal socialization among the young school students which, given the socio-economic background prevailing in Malawi, ultimately impacts on medical choices.

1.5 Definitions

A non-judgmental approach to traditional medicine is adopted. Traditional medicine will be defined, reflective of its power, to include both positive culture-bound healing medical practices - with their associated beliefs - by herbalists, diviners, religious workers who treat illness, birth attendants and other practitioners and negative *ufiti* practices (associated with witchcraft and sorcery) with their malign elements (Cf. Kapapa, 1979: 1- 4; Maclean, 1986: 9 – 13; Yamba, 1997: 200 - 223).²⁹

In this work *sing'anga* denotes a professional practitioner in various traditional healing medical practices. While *sing'angas* can prevent, cure or ameliorate diseases caused by witchcraft (*ufiti*), they are here distinguished from those who practice witchcraft (*afiti*), *afiti eni eni*. Corrupt *sing'angas* can provide the means to poison others without themselves being *afiti*, an act of abetting *ufiti*.

Culture is here defined as the totality of the inherited ideas, beliefs, values and

²⁹ This definition also takes into account the Malawi usage of the term traditional medicine. It is favoured because of its contextualisation of culture with the environment in which it is practised. The Malawi 'Vision 2020' Project, so far the most comprehensive, participative and scholarly attempt at defining post-colonial Malawi, uses this definition.

knowledges, which constitute the shared bases of social action. Or as defined at the Malawi Vision 2020 conference:

the essence of a given people's way of life, as represented by their multi-faceted creations, accomplishments, and aspirations... ideas, food, dance, dress, language, institutions, beliefs, and other habits learned by people through the learning process. It also includes the material objects that people have created and continue to create from the local environment, and techniques for creating them... The Malawian culture is ...multi-ethnic (Ng'ombe & Mawaya, 1997: Section five).

Culture tends to contextualise science even in the western paradigm (see Butchart, 1998: 122 - 123). Qureshi (1994, ix), in the context of British medicine, posits that 'scien[tific] variables should be understood to include age, sex, social class, race, religion and culture'. Indeed Althusser maintains that [science] is itself the product of social practices (Sarup, 1993: 77). If we substitute 'culture' for 'social', this is in line with the activist conception of human beings (Fay, 1987). Culture and politics, as dynamic phenomena, may impact on personal and national health.

In some sections, the concept of traditionality is preferred to tradition or culture. This is the concept of appropriate rather than necessarily backward traditional systems or mechanisms coping with reality. This work suggests traditionality as a positive construct based on traditional concepts and or *anthu wamba* (the peasantry) responses to and interactions with modernity.³⁰

To avoid employing 'meaning as in-built bias' via unintended characterising and appraising (Nagel 1961, 492-5) the term western medicine, to describe government and mission western orthodox medicine, is here preferred in contrast to 'modern medicine'. I note that in Zimbabwe, Chavunduka (1986, 59-72) and his colleagues have opted to use the term 'traditional medicine' for indigenous medical services. In Malawi, too, most leading scholars and academics use the term 'traditional medicine' (Kapapa,

³⁰ The traditionality concept here would reject Chabal's assertion that 'traditionalisation makes westernisation problematic'. Chabal (1999: 46) misses the point (we will develop later) that to become westernised one needs the appropriate socio-economic context. Traditionality is used here in its positive sense. It is not used in the sense of backward movement to an earlier colonial or pre-colonial period. Traditionality in this discourse is an attempt by people living in places transversed by a given set of contexts and 'modernity' to make sense of their lives (Cf. Bayart, 2000: 264 – 267).

1979; Msonthi, 1982; Ndibwani, Henry and Saka, 1998; Chakanza, 1999).

In this work *ufiti* (witchcraft), in its reality as a negative malign practice, is distinguished from positive healing practices.

1.6 Theoretical considerations and justification for the paradigm

The problem of studying Malawian culture in the postmodern period demanded a reappraisal of whatever western grounded theory was to be applied if the charges of denying Fay's (1987: 215) 'possibility and limit' to this culture are to be avoided. Despite its limitations (Cf. Spivak, 1988, 1990; Bhabha, 1994) Foucauldian theory has been utilized to assert validity for different and localized knowledges.³¹

If the work of Franz Fanon (1961) and others was, with hindsight, the usable tool of the anti-colonialist discourse,³² then work of Foucault, as developed by, for example, Mudimbe (1988) and Appiah (1992), could be said to play similar roles in post-colonial African Studies discourse.³³ For example, two works, Vaughan's classic of 1991 and Butchart's 1998, offer Foucault influenced analyses of African colonial socio-medical discourses. Vaughan attempts, using Central and Southern African resource material, to explore 'the conflicts within medical discourse' in colonial Africa brought about by 'pretensions to scientific neutrality and its political and cultural motivation' while Butchart 'applies some of the theoretical tools developed by Foucault [and others] to the problem of the African body, as it exists, to western socio-medical science in Africa.'³⁴ Surprisingly, Butchart's is, despite being more Foucauldian, less political in orientation than the earlier work. Both, however, provide examples of post-colonial examinations of, essentially, colonial medical issues.

³¹ Foucault's power/ knowledge concept; his assertions that power is every where (as are resistances to that power); and his emphasis of local specific struggles, can be useful in examining rural societies and their hierarchical systems based on knowledge, age and gender as well as their unwritten 'traditional' dynamic norms.

³² In its contestation of the privileging of colonial power's cultural concepts.

³³ 'Post-colonial' denoting 'discourses informed by epistemologies and psychological orientations of the postcolony' and 'postcolonial' meaning 'after colonialism'.

³⁴ Although based on South African material, and potentially more political, Butchart's is ultimately less 'political' than Vaughan's earlier work.

But post-colonial African social science discourse is currently engaged with the problems resulting from the colonial assault as well as with the resultant postcolonial identities, cultures, epistemologies, hermeneutics and, of course, post-colonial governmentality. In the African context, both the colonial episodes and the almost universal postcolonial hegemonic regimes can be seen in terms of power dynamics, 'productive', selfishly accumulative or wantonly autocratic. In their similarity to the colonial regimes the postcolonial hegemonic regimes in Africa, such as Malawi had, resemble repressive power models rather than objects of productive power (Cf. Africa Watch, 1990). Fanon rightly predicted that, faced with socio-economic problems, many postcolonial African leaders would hark back to history and its effects in instilling national unity (Fanon 1964: 99 - 102). In the event Franz Fanon's theory - which emphasised differences - became subversive to the new postcolonial order since it stigmatised the elites as exploiters. The elites were not interested in his suggestion of assembling another post-colonial identity; they had, after all, inherited the functional ontology, received epistemologies and methodologies from the colonial regime. Predictably, post-colonial, academic inquiry and discourse, as with nationalist political discourse during colonialism, remained constrained (Cf. Falola, 1996: 11 - 16).

The economic and social theorist Dunduzu Chisiza (1961) predicted this for Malawi; where discourses of difference contested the received postcolony, the constraining hand was especially severe. This delayed the process of 'studying the present and analysing the past' (Mkandawire, T., 1997: 15 - 36).³⁵

In the postcolony, given the possibility of the liberation from European dominated perspectives, there is a need to reassess the 'knowledge claims and practices' of the human sciences - medicine, psychiatry, psychology and sociology' (Sarup, 1993: 72) using new paradigms if indeed power is the 'ultimate principle of social reality' (Sarup, 1993: 730). Assuming that this new reality was liberated by the 'rupture' of the colonial state, this rupture produced only a limited discourse to counteract the 'historically dated

³⁵ Africa Watch (1990) produced a report, which detailed the extent of Dr Banda's state repression in economic, cultural, journalistic, and other intellectual discourse (Cf. Short, 1974; Williams, 1978, Cullen, 1994).

and culture specific discourses', as those of Levy-Bruhl (1926),³⁶ whose truth claims and values amounted to 'no more than a transient episode in the modern history of ideas' (Sarup, 1993: 75).

My study examines politics, culture and western and traditional medicine in postcolonial Malawi; and will attempt to analyse the dynamic between politics, culture and medicine - both western and traditional. To achieve this validity has to be accorded to both traditions.

The work questions, if only indirectly, the extent to which the western socio-medical paradigm has been absorbed and or syncretised into the culture of health and healing, given a hypothesised abiding strength of the traditional indigenous culture. In Chapters Three and Five I also question whether syncretisation has been 'parallel or one of hybridity'.³⁷ Hybridity, a theme current in African social science discourses, is itself a metaphor suggesting that all 'power/knowledge' relationships are the results of contestation and negotiation.

The dual use of both western and traditional medicine, and the implied duality of beliefs, can theoretically be predicted given the given the socio-economic realities in Malawi (Cf. World Bank, 1995). Here Mbiti's (1975: 170-171) illustration of the intimate relationship between medicine, culture and politics is largely still apposite:

For African peoples, the word medicine has a lot of meaning... Traditional African medicine is used for many purposes, one of which is to put things right and to counter the forces of mystical evil. There are, therefore [those] engaged in the positive use of mystical forces... [chiefly] the medicine men, herbalists, diviners, mediums, rainmakers, priests and even rulers... They help to stabilise society with their knowledge, skill and religious activities like prayers and rituals and sacrifices. They are the channels of good health, good fortune, fertility, peace and welfare. [They] work [to counteract] the many enemies of society we mentioned above. For that reason they are the true friends of society and a public asset.

³⁶ Levy-Bruhl's concept of a primitive mentality unable to apply certain logical constructs denies the concept of mankind's 'psychic unity'.

³⁷ When one culture and another give birth to a new entity that is different but also naturally retains the identities of its origins (Portella, 2000).

It is worth noting here that in the Chewa language *moyo* denotes *life* and *health*, as well as aspects of culture, as in *moyo wa masiku ano* (today's culture, mores). In Tumbuka today's mores or culture translates as *moyo wa lero*.

My study probes aspects of Malawian culture using a western methodology. At the outset several assumptions have to be made; the most obvious being the rejection of the Hallpike (1979) and Levy-Bruhl (1926) discourses on African modes-of thought - for the reasons given by Mudimbe (1988: 187 – 203) and Hallen (1997: 1- 11). These schools of thought essentially saw West Europeans as rational scientific beings unencumbered by 'tribal mystical' cultural baggage of 'tribal cultures'. I also reject some of Durkheim's (1912) ideas as 'philosophies of conquest' grounded in western ethnocentric modalities of being, current in colonial times. Even in contemporary social science culture is a concept, more often than not, ascribed to 'indigenous peoples'. Fay's (1987: 163) comments on tradition are relevant in this regard:

Logically, to be a being which has no cultural inheritance is not to be a person: it is to be utterly silent, without any beliefs, any desires, or any thought processes whatsoever; and psychologically, to be a being which is able to dissociate itself from its culture, such that it can rationally criticise any and all parts of it, is a figment of some Enlightenment inspired imagination, a figment not recognisably human.

Having established the virtual impossibility of being acultural Fay continues:

Human beings are forever set within particular traditions, which, in being appropriated, partially define their identity. They of course are not passive sponges in this process: they affirm some of their inheritance and they reject other parts of it; they cultivate and they transmute; they embrace, they recombine in novel ways, they create. But all their activity always involves the appropriation of materials given to them by their tradition; it is the stuff out of which their development and change is made. That is what is meant by saying that humans are traditional beings (Fay 1987: 164).

Scholars who have questioned the privileging of European cultural concepts over others have opened up useful avenues of debating and examining other cultures. However, in spite of rejecting some of the colonial European analyses and conclusions (Cf. Said, 1978), it is recognized here that colonial observations, representations,

misrepresentations and interpretations of Malawian culture can be informative, even if, 'value loaded' records of the time.

Mudimbe (1988) has outlined a 'genealogy and archaeology' of African philosophy, attempting to define what is and what is not African philosophy. He posits that western anthropologists and missionaries distorted both Africans own understanding of themselves and the outside world's understanding of Africa. Yet Mudimbe's own work shows the dilemma of African scholars: all methodologies, form and style of Africanising and theorising this very African knowledge is mostly in western form - what Hallen (1997: 1) has termed 'African meanings, Western words'. Mudimbe (1988: ix and 199 - 200) uses the notion of 'conditions of possibility' to show that 'discourses have both socio-historical origins and epistemological contexts'.

Some scholars (Cf. Spivak, 1987) view the postcolony in terms of differences, an approach, at first sight, resonant with Malawi's (and Africa's) multiple ethnic and cultural fabric. We can, for the purposes of this work, appropriate the emphasis on differences, differences between ethnic groups, males and females. And the localized cultural practices, mostly dealt with here, are by definition, replete with differences. However, the real life worlds of postcolonial 'national' political and cultural power brokers are not keen on differences - their discourse is about national unity, real, constructed and imagined. Yet again, therefore western social theories may not easily apply.

A pertinent question underlining my research is the validity and effectiveness of western social theories in examining indigenous Malawian culture. Linda Smith (1998), in an attempt at 'de-colonising research methodology', firstly critiques the 'historical and philosophical base of western research' in respect of 'imperialism, knowledge and research'. Then she shows how well planned indigenous research - by 'reclaiming control over ways of knowing and being' - can be both 'emancipatory and valid'. Thus, using western methodologies that value indigenous cultures, an examination of these cultures is possible. This is the approach followed in this study.

The need to reassemble and reclaim the past in order to understand the present faces a

major hurdle in that Africa's historical base is largely oral. And positing the colonial phase as a discontinuity may facilitate the charges that reduce chunks of present indigenous culture into reassembled constructs, as some historians contend (Cf. Hobsbawm and Ranger, 1983; Werbner & Ranger 1996).³⁸ Here I find attractive the school of thought viewing the colonial phase as a factor configuring duality and hybridisation alongside and within a continuous indigenous culture (Cf. Falola, 1996: 11 - 16).

Accepting that the colonial phase constructed the current African social studies environment, for good or ill, with its power/knowledge legacy and methodologies begs the question: How do these inherited post-colonial power/knowledge residues affect our current view of the rural indigenous culture which we may posit as the more 'continuing' African culture?³⁹ The answer will of course depend on which methodological tool we use. Forster (1994: 477 - 497) gave an answer that was useful in political analysis (that tradition can be re-used). Forster's implied re-invention is contested here; Banda attempted to re-store what he saw as a Chewa imperial system. A living tradition is constantly renewed and adapted. Re-invention only applies where there has been a complete rupture;⁴⁰ our reality of localized traditions ensured that colonialism did not cause a complete rupture.

Further, it could be argued that a culture of orality permits a degree of latitude and continuity in cultural norms, dynamics that may be seen as 'inventions'. Ranger's assertion that

the second ambiguous legacy is that of 'traditional' African culture; the whole body of reified 'tradition' invented by colonial administrators, missionaries, 'progressive traditionalists, elders and anthropologists. Those like Ngugi who repudiate bourgeois elite culture face the ironic danger of embracing another set of colonial inventions instead (Ranger, 1983: 261 – 262)...

does not entirely stand the scrutiny of subsequent post-coloniality. For Malawi, a study

³⁸ If only seen from a written perspective. In an oral culture historical continuity is preserved by orality.

³⁹ See chapter two for this discussion.

⁴⁰ Even the drastic conditions of the North American slave trade failed to achieve complete cultural rupture as shown specifically by the African cultural traditions manifested in parts of the United States, Haiti and Brazil.

of the colonial and postcolonial works on the *nyau*, African Traditional Religion, indigenous customs and dances and their arts and crafts suggest that considerable localised continuities of these 'traditional' cultures were preserved, not on a micro but macro scale (Cf. Abdallah, 1919; Birch de Aguilar, 1994; Breugel, [first published 1972] 2001; Kaspin, 1993; Ntara, 1973; Phiri, K, 1975).⁴¹ Even a critical examination of colonial texts, once shorn of the value judgements of the time, present people with oral histories, many of which stood up to subsequent scrutiny. Accounts, like the one by Tew (1950) for example, give a sketch of people who are very well organised, with religious, economic and cultural traditions. The same analysis can be made from Johnston (1897). The problem of identification of this culture has always lain with the social scientists; their gaze is largely on the written texts and European colonial views, rather than the localised practices and oral or musical carriers of the tradition.

Ranger's work emphasises colonial 'reification' of appropriated European and African traditions by educated Africans, for political and economic reasons, and colonialism inventing African tribes. Indeed in his study of *Beni* in East Africa, Ranger is dealing with hybridized Africans who may or may not have been 're-tribalised' or 'westernized'. Ranger's own recognition of the 'continuity and innovation, which resides within indigenous cultures as they have continued to develop underneath the rigidities of codified colonial custom' (1983: 262) subverts his re-invention argument. In many cases the localized indigenous practices were largely protected from Ranger's reification'.

The present work takes the stance that oral traditions and cultures are dynamic and, where external forces impact on them causing alterations changes and hybridity formation, can be, to varying degrees of perfection, restored and replaced from the memory. The acts of restoration and replacement that may involve aspects of re-invention tend to occur in the arena where African orality meets western literacy, for example Rangers 'exploited groups with which Ngugi has sympathy'(1983: 261). These are hybrids, rejected by western African modernity for a host of reasons, which

⁴¹ Further an examination of the work of others, for example Stuart (1976), Schoffeleers 1979), Breugel (2001), Linden (1975), and others, show - in their narratives, description of resistance and identity - the inherent continuity of the traditions studied.

seek a return to cultural values without abandoning their western heritage.

In sum then, to re-invent, one need not have known about something; to restore on the other hand implies putting back in place something that had been forbidden, lost, mislaid or stolen.

Finally, we address the question of the epistemological compatibility between western medicine and traditional medicine. Newer social theories recognise the variability of cultural practices and their different meanings and enable us to study phenomenology and epistemology using newer and more radical, but peer validated, methods. Fay's (1987: 203 -215) triple claims - that humans are unfree and dominated by situations beyond their control and understanding; that they do not have to be in this state; and that an increase in knowledge is the only way of liberating themselves – is useful, but if only we first decide which knowledge would be liberating in the Malawian context, western or Malawian? Here, given the colonial history and globalisation, I would argue that a good knowledge of both is essential. Take for example the ontological and epistemological issues raised by the following vignette:

As a westernised Christian secondary school fourteen year old I frequently argued with a local village elder. Although a devout Muslim, it was his ideas of African culture and philosophy that formed the basis of our friendly exchanges; I had been brought up to reject, and indeed, despise aspects of African culture as 'primitive'. I naively always assumed that I won the arguments until one day he found me reluctant to enter the lake. The east to west *vuma* winds had turned the waters of Lake Malawi a dirty brown colour at the beach.⁴² I was about to return home unwashed because the water was "so dirty and unclean" when he chided me.

"Water can *never* be unclean", he declared, not in the ignorance of a Levy-Bruhl subject - he knew about bilharzia and microbes and, via travel to Mecca and South Africa, had a more than 'regional world-view', "water is the universal and ultimate solvent!" (Lwanda, 1994: 67).

This philosophical view is, with hindsight, clearly appropriate to Malindi, where no running water was available in 1964; in 2002, only a third of the villagers have easy

⁴² Strong east to west winds that blow between June and August over Lake Malawi.

access to water stand pipes.⁴³ This philosophical viewpoint is also capable of universal application on a wider philosophical terrain given the ecological debates now raging. Yet, given the same scenario, an early colonial official, or indeed a hybridized African youth (with access to hot water at his secondary school), might have mistaken this view as that of someone who does not object to washing in 'dirty water'. Some colonial and postcolonial observers mistook pragmatism for ignorance. We pursue this point further in Chapters Five and Six, where we show that knowledge on its own without the socio-economic means to build on that knowledge leads to paralysis.

Further, there was a misunderstanding of some indigenous Malawian concepts due, partly to language, conflict, class, racial preconceptions and other factors. For example, a Chewa proverb goes:

Mtedza subala nzama (Peanuts do not produce bambara nuts)
Mapila sabala nandolo (Sorghum does not produce pigeon peas)
Chinangwa sichibala mbatata (Cassava does not produce potatoes)

Yet contrary to the 'fixed and real' magical thought of Levy-Bruhl's 'prelogism' the saying does not end there; it has a metaphysical ending:

Zikatelo zidzadabwitsa wanthu (If that happens it will surprise people)

This ending was not, if at all, usually expressed in colonial contexts. The Chewa certainly knew about 'possibilities' long before Foucault.⁴⁴

I therefore relocated my discourse to a dialectical level with the equation: let western medicine know about traditional medicine and vice versa, using an eclectic triangulation methodology approach. This involved an attempt at demystifying both sides of the epistemological equation. As Outhwaite (1987: 116 - 117) has concluded:

... the essential point is that the social sciences require a plurality of methodological approaches, no less than the natural sciences. The merits

⁴³ Any 'modernised school leaver', who took the view that they would not use lake water at Malindi, and managed to survive, would have to leave Malindi.

⁴⁴ Patrick O'Malley (28/4/02), himself a postcolonial missionary, notes that many missionaries, often from peasant and rural backgrounds with strong 'traditional practices' of their own, were strangely often unable to adopt open attitudes to similar elements in the 'cultures they came to convert'.

of these approaches can only be judged in the practice of these sciences and the extent to which they seem, to social scientists and to the public, to enrich our understanding of the social world.

The time has come, I think, to build on these insights in the ways in which Habermas, Bourdieu, Giddens and others have done. And it seems to me that a realist philosophy of science and a qualified or critical naturalism provides the best meta-theoretical framework for further development'.

Aspects of functionalist and structuralist theory as described by Giddens (1989: 690 – 716) are utilized in this study.

1.7 Causality, Validity and validation in Traditional medicine

The foregoing discussion both begs and answers this study's approach to the question of the validity or otherwise of traditional medicine. The validity of African traditional medicine has suffered from the causality debates of the colonial and postcolonial era.

The causality debates in colonial times emphasised, and perhaps romanticised, the witchcraft aspects at the expense of their social and utilitarian context and roles (Cf. Evans-Pritchard, 1937; Parrinder, 1956). European anthropologists like Evans-Pritchard and Levy-Bruhl saw aspects of African culture from a perspective that regarded European culture as superior. They saw African culture as symbolic, superstitious and magical. This perspective can be excused given the attitudes of the period; it is however, from the point of view of this study, more difficult to excuse their failure to note the appropriateness of the beliefs and practices in their socio-economic contexts.

Various scholars, Lambo (1963); Mbiti (1975; Mudimbe (1989); Appiah (1992), and others have offered alternative explanations and critiques of these attitudes. In the Malawian context, the work of Schoffeleers (1979), Breugel (2001), and others, and more recently, Ott (2000), Chakanza (2001) and others, have also added to a growing literature that explains the context of some of the Malawian beliefs and practices from anthropological, religious and other perspectives. This work builds on the work of others to argue for the validity of traditional practices in their socio-economic contexts, their success being measured by their ability to prevent *mtundu watha* (the clan/tribe

perishing) or *tikutha* (we perish).

In this context it is interesting that Lincoln et al. (1985: 137) see causes as human impositions 'upon a continuous stream of occurrence'. They further see this imposition as 'based on the researcher's purposes and interests' (Baptiste, 2001: 8). Lincoln et al. (2000: 165) also argued that critical theory offers

historical realism, [a] virtual reality shaped by social, political ... values, crystallised over time.

In this respect they saw constructivism as representing 'local and specific constructed realities' (Lincoln et al, 2000: 165), with social phenomena being results of 'meaning-making activities of groups and individuals' (ibid: 167). The concept of local realities and knowledges and meaning construction is pursued in this work.

Causality issues are discussed further in Chapters Four and Five.

This work takes the stance that all cultures are the products of the interaction between their environments, resources and their aspirations, needs and imaginations. A culture under study, therefore, has to be approached in its ontological reality. In the case of Malawi, traditional medicine has been involved in maintaining order, disease prevention and control, and in treating disease. Seen from this perspective, the explicative hows and whys may be more appropriate than questioning the validity of practices that, in their way, have been effective for centuries.

Medicine, as the western alternative medicine discourse confirms, exists in duality, between the 'scientific' and the 'symbolic' to varying degrees, in most cultures (Scott, 1998: 21 - 37). This alternative possibility was largely denied in Malawi. Western methodologies - Christian and colonial - viewed traditional medical practices as superstitious, unscientific and defying 'rational' logic (Mitchell: 1952: 51 - 58; Evans-Pritchard 1937), western knowledges being held to be rational and superior. This is, as Willis (1986: 214 - 215), talking about symbolic healing,⁴⁵ points out, a matter of

⁴⁵ Of which more later in 5.3.1 and 5.4.1.2.

cosmology:

In learning to understand what happens in symbolic healing, it should encourage us to recall that since Heisenberg's famous experiment in 1926, western physicists have managed to dispense with Cartesian framework and contrived to think, with notable success, in terms of a new cosmology wherein the old boundaries between mind and matter, subject and object, have been dissolved and replaced by relations of complementarity. When we Western scientists have managed to free ourselves from the constraints of an outmoded conception of what science is, we should be better able to approach and understand the ideas and practices of these, to better understand ourselves.⁴⁶

This approach inevitably begs the question of who carries out this validation.

In its natural setting, traditional medicine's validation is by repute, experience, ethics, and, of course, outcomes in the form of cures achieved, fertilities attained and evil or misfortune warded off. It is also by membership of a legitimising association, whether government registration, peer or family traditional healers 'collective'. One of my informants, Mr Kachule (Personal Interview 1/7/00), a driver from Area 25 in Lilongwe, for example, clearly makes a distinction between the 'new' *sing'angas* and the genuine ones. The *weni weni* (the real ones) are, in his view, associated with a pedigree and training of some kind, unlike the 'modern day ones' (vide infra). Even the modern ones, though syncretic and lacking pedigrees, may in their utility and 'efforts to redefine a changing social world in terms of familiar avenues of recourse and associative networks (Jules-Rosette, 1981)' be amenable to validation using the criteria of functionality, availability and their ability to achieve some degree of collective societal health improvement. Practitioners will be judged by the efficacy of their *Mtsiliko* (a medicine that protects against sorcery or theft from houses, granaries and gardens); the efficacy of their *Mphinjiri* (a medicine that protects from misfortune); the potency of their *zithumwa* (a charm that enables one to acquire desired objects or repel misfortune).

Usually, prior to their use, evaluation of *sing'angas* occurs. 'Genuine ones', not 'one of these modern ones' is how Mr Kachule put it when distinguishing between the 'new'

⁴⁶ In my view western anthropologists were more obsessed with African symbolic healing than herbal or other indigenous medical practices. These symbolic aspects were emphasised in ways that exaggerated the 'superstitious' elements. This discussion is revisited in Chapter Five.

sing'angas and the *weni weni*. The latter were contrasted with the 'modern day ones' (*amasiku ano*). '*Amasiku anowa*' here tended to be those who resorted to herbalism, some after hitting hard times. They would tend not to have received their calling in dreams, as is traditionally accepted. Dreams as a calling to traditional medical practice are often cited. Kumpolota (Personal interview, 18/7/00) cites dreams, which occurred to him after a period of illness.

Upon their calling, traditional practitioners may 'train under a master' until they have developed the necessary skills to practice. Their instructions include herbalism, psychology, traditional beliefs and cultural practices. They are taught about herbs as well as being instructed in their various codes of practice (Wilkinson et al., 1991: 223 – 224). A feature of professional practitioners is their adherence to some code of ethics and avoidance rules. Some may avoid alcohol, or foods. Breaking these rules is thought to dilute the potency of, or make, their medicines useless. This apprenticeship form of training is common in rural areas (Chalanda, 1987: 31). Here some may travel to a well-known practitioner and live with him until he is satisfied their apprenticeship is complete. Like western practitioners, traditional practitioners have their own tools of the trade, which are used in diagnosis; these include mirrors, flywhisks, gourds with medicines used in diagnosis, rattles, horns, and various bones.

Validation will also have to take into account the existence of non-professional healers and herbalists, part-time traditional health workers. These, sometimes, self-taught practitioners acquire healing knowledge and skills. Last et al. (1986: 267) suggest that any validation exercise will fail unless it takes into account the symbolic, ritual and social matrix within which it is used; it is these which contribute to traditional medicine's meaning at any particular time or place. The problem is that validation exercises may place emphasis on pharmacological knowledge alone. Some traditional medicine works at the pharmaceutical level (Msonthi, 1982: 81 - 85; Morris, 1996). Significantly, it also works at the religious level (MacLean, 1986: 9), at the social level (Hours, 1986: 41), the homeopathic level, at the political level (Lwanda, 1996: 283 – 284; Schoffeleers, 1999), and at the psychological level (Last et al, 1986: 3). Any validation exercises have to take note of all these aspects.

In Malawi, validation is, at the individual level, by patients and, as in western medicine, can be influenced by non-medical factors like availability, affordability, affability of practitioners, and inevitably, but not necessarily, effectiveness. In the communal arena the validity of their work is judged by their effectiveness, spread by word of mouth, as well as their ability to ensure communal good health and order. The considerable power and influence, which traditional practitioners can wield, is demonstrated by the size of the following that Chisupe managed to attract (Lwanda, 1996: Schoffeleers, 1999).

1.8 Outline of the thesis

In Chapter One I utilise reflexivity (Hammersley and Atkinson, 1983) to outline my background, theoretical framework, values and other personal factors that may impact on the study. This reflexive element also gives the context – and hence the methods chosen - within which the study is located.

In Chapter Two I utilise literature search and review, archival research, participant observations and oral interview methods to construct a model of pre-colonial medicine. The information gathered was then subjected to textual analysis and criticism and merged with information from a modelling concept, to re-construct a pre-colonial framework of health care.

In Chapter Three I examine the colonial and post-colonial historical perspectives, including aspects of colonial western medicine, education and traditional culture in Malawi. Western medicine is critically analysed and contrasted with its linkage to, relationship to and responsiveness to indigenous cultures within the cultural and political contexts of the colonial and postcolonial period.⁴⁷ This chapter makes the point that, due to the strength and appropriateness of the traditional framework, limited resources and other factors, neither the colonial nor the postcolonial dispensations abolished rural localised forms of this pre-colonial framework. These survive in rural localities.

⁴⁷ The 'scientific medicine' introduced to Malawi by the British. Excludes 'alternative medicine'.

In Chapter Four, after flagging relevant epidemiological and clinical aspects of HIV/AIDS, I proceed to examine the history of HIV/AIDS in Malawi. The chapter traces the unfolding of the HIV epidemic by subjecting archival and oral data to historical analysis. The Chapter demonstrates how cultural and political factors affected the responses to HIV/AIDS and, consequently, its magnitude. The limited dialogue between traditional and western medicine, despite the former's major service provision role, is highlighted. The point is made that, as under colonialism, the western model of public health promotion and treatment can only reach a limited segment of the population. The chapter also makes the point that due to the failure of western oriented health promotion agencies to engage localised traditions early, some foci of HIV infections will prove difficult to dislodge.

In Chapter Five I report the results of my fieldwork, which includes literature reviews, quantitative and qualitative questionnaire surveys of primary and secondary school students and others in Zomba and Malindi, participant observation, interviews with some key informants, such as traditional medical practitioners, doctors, nurses and herbalists and audio and video recordings.

The material thus gathered is consolidated into a chapter detailing and analysing the prevailing cultural beliefs and attitudes, with an emphasis on the attitudes of students in primary secondary and tertiary education. After outlining the methodology utilised there is a theoretical discussion of how the educational system in Malawi is affected by cultural, political and economic forces. The point is made that due to under-resourcing and the resultant dependence of primary and many secondary schools on what we term village-culture, the developmentalist intentions of the school syllabus are not often achieved. Schools, both primary and secondary are, however, noted to be successful in delivering the lucky small minority to the next level of education. These lucky students become the elites who later control resources. Their almost miraculous transit through the system may imbue them with a justified sense of privilege, luck or superiority, qualities which are later seen in resource allocators.⁴⁸

⁴⁸ This aspect is, in rural discourse, covered by the term *azungu* (white people), a reflection of the privileges enjoyed by these elites, which are perceived as being comparable to those previously enjoyed by white people only. In this sense the term *azungu* has class, rather than 'racial' connotations.

From the fieldwork, it was also found that primary and secondary schools are successful in imparting what we term the scientific facts about HIV/AIDS causes, preventions and treatments. There was, noticeably, a preponderance of an aspirational abstentionist discourse at the expense of practical measures to prevent infections.

In examining the prevailing cultural background using the markers, it is noted that *ufiti* (witchcraft) discourse - because of its historical continuity and its persistence in localities due to socio-economic circumstances – continues to thrive. This *ufiti* discourse is adopted and used by students, and the general population, in discursive and jocular modes. It is also used in an unquantifiable section of (and, it is here argued, not the whole of) the population in serious realistic mode.⁴⁹ It is also argued that the use of this *ufiti* discourse is ‘helpful’ in explaining away and coping with the enormity of HIV/AIDS illnesses and deaths. This aspect may manifest as national or personal denial of the existence of AIDS illness in a particular situation.

An examination of the government media will show that *ufiti* discourse is utilised by governance in modes that control order and legitimise the denial of resources to ordinary people. An allied use of *ufiti* discourse was in achieving subtle public socialising, for example in crime prevention; this was a process allied to *kukhwima* (fortification). From the perspective of HIV/AIDS, these mechanisms and dynamics have a negative and dilutory effect on western models of health promotion. It will be shown that the almost perfect knowledge the students acquire about the causes of HIV/AIDS becomes an impotent theoretical tool they are subsequently unable to use primarily because of the lack of resources. The localised cultural village norms, given the socio-economic context, will then be shown to offer alternative coping strategies.

Chapter Six, which also benefited from my fieldwork, ties up the loose ends in Chapter Five by examining why and how cultural attitudes and beliefs are, in the context of Malawi’s socio-economic environment, developed and maintained. A concept of how cultural attitudes and beliefs are developed and maintained is constructed from the

⁴⁹ My figures from the student surveys did not support an overwhelming belief in *ufiti* among those in school education.

interplay between my ideas and the material from the fieldwork against critical reviews of previous study material. The chapter demonstrates how this socialisation relates to the development of attitudes and beliefs to western medicine and HIV/AIDS. Here the strands of the thesis are brought together to demonstrate the dynamic between culture, medicine and politics as it relates to HIV/AIDS perception, prevention and, ultimately, containment.

Chapter Seven contains the conclusions, implications and suggestions for further work in this field.

Before continuing to Chapter Two it is perhaps more appropriate that I critique my work here.

1.9 Critical assessment of my own work

One of the major difficulties was identified early. HIV/AIDS is a multidisciplinary problem involving sociology, medicine, politics, demography, history, anthropology, and other disciplines, with all the complexities and conflicts of methodologies that that entails. However, I was of the opinion that, for completeness, any study on HIV/AIDS in Malawi needs to include these and culture in the framework. My approach was to attempt a separation of the various strands without losing sight of the whole. In a study of this length some subjects may receive more coverage, at the expense of others.

The problems of my own motivation, perspectives and ability to remain non-judgemental were always in the background. I made considerable efforts, including frequent reflexivity, to overcome these. The critical input of my supervisors was very helpful in this regard. Further limitations, in terms of resources, time, opportunities for prolonged interaction with others in the field, were always inevitable. Helpful contacts and insights were obtained through attending a number of seminars and conferences, at universities in Glasgow, Stirling, Zomba (Malawi), Houston (Texas) and Edinburgh itself.

This multidisciplinary study is limited in a number of directions because of the

constraints of space. For example, even though western medicine was introduced into Malawi by both government and missionaries, this thesis deals mainly with the government services. The development of government services, in a number of ways, paralleled that of mission service (Cf. Baker, 1975; King and King, 1992).⁵⁰ A number of other limitations of the study are pointed out in the individual chapters.

My own approach is largely informed by medical, political and cultural pragmatism. Having read a number of discourses dealing with the HIV/AIDS pandemic, I was struck at how many of them took single theme strategies that could only be applied to the Malawian context if most Malawians, in the words of one of my informants, Mr Tembo (Personal interview, 15/7/2001) 'became saints'. I was determined to avoid this approach. But this introduced a problem of scale, magnitude and resource into the work. At no time therefore, is recourse made to claiming 'ethnographic authority'.

Other limiting factors included my chosen methodologies to interrogate the relationship between medicine, culture and politics. In this respect, I was acutely aware, at all times that in social and behavioural science 'knowledge is always partial and intrinsically incomplete (Fielding et al., 2001: 16).

1.10 Chapter Conclusion

This Chapter has outlined the reasons behind the study, the research questions, the methods, and definitions of some crucial terms. An account of some theoretical assumptions and potential controversies has been included. Here we have also flagged up issues of causality, validity and validation in traditional medicine; these will be addressed in various parts of the thesis. A number of limitations in the study have also been indicated.

⁵⁰ An examination of missionary medical services is, because of constraints of space, beyond the present work. Shepperson and Price (1958); Ross, A. C (1968 but published 1996); Gelfand (1964); Linden (1974); McCracken (1977); King and King (1992) and others examine and highlight the prominence of missionaries in the development of western medicine in Malawi.

CHAPTER TWO

PRE-COLONIAL HISTORICAL PERSPECTIVES

Balala! balala! (Scatter! Scatter!)
Mabvuto mbuyomo! (Trouble follows behind!)
*Tiyeni tithawe! (Let us all run away!)*⁵¹

2.1 Introduction

This chapter, which views social constructions as partly and significantly based on [historical] experiences - famine, epidemics, war, peace or internal strife - seeks to locate present Malawi HIV/AIDS debates in a terrain that includes continuities and ruptures from pre-colonial times.⁵² Here colonisation is viewed as a brief, if significant, 'socio-political and cultural assault' and post-coloniality an ambiguous socio-political and cultural 're-inventive and re-assertive' factor.

This chapter suggests that:

- Using historical responses to medical and social illnesses/epidemics, the construction of a pre-colonial framework for public health is possible.
- This framework, as will be examined in subsequent chapters, was not abolished by either colonialism or postcolonialism.

Chapter Methodology

Chapter two utilizes literature search and review, archival research, participant observations, oral interview and historical research methods (Robinson and Reed, 1998: 47; Cormack, 1996: 166 –177) to construct a model of pre-colonial medicine. I obtained my information in the following manner:

⁵¹ A traditional Chewa/Ngoni song warning of impending strife.

⁵² 'Unending dialogue between the present and the past...' (Carr, 1970)

- Personal archival material built between 1983 and 1995. Initially this was mostly material of a cultural, musical and pictorial nature or monographs and articles. Later this collection began to include historical and political articles and documents, later much augmented by collections during my visits to Malawi in 1993, 1994, and 1997. I worked in Malawi between 1994 and 1995. Partly out of this material I published two books.⁵³ This experience helped shape the background to this research.
- Consulting archival and oral sources of data in various British universities (Appendix 2).
- Consulting the Malawi National Archives (Appendix 2).
- Consulting libraries and documentation centres in Malawi and the United Kingdom. (Appendix 1).
- By interviewing informants (See the reference section).

A number of difficulties were encountered. Searching for articles on Malawi, a relatively obscure part of the world, is difficult, time consuming and expensive. And specifically, articles on pre-colonial Malawian traditional medicine, outside colonial texts and orality, are difficult to find. It was initially difficult to trace recent theses on Malawian history and culture; the use of Internet searches and the Royal College of Edinburgh Library simplified this problem.

The information gathered was then subjected, using historical research methods, to textual analysis and criticism and merged with information from a modelling concept,⁵⁴

⁵³ Lwanda (1993) and Lwanda (1996).

⁵⁴ Based on my observations and studies of the life worlds of rural Malawi. From 1966 when, as a secondary school student, I took part in a census count in a very rural and previously little inhabited part of Namwera after Mozambique refugees had literally 'flooded' into Malawi. Two phenomena had occurred: those refugees who settled among established villages became part of the established village order; those who settled in previously uninhabited areas had to establish their own new authorities and hierarchies of order and formalise the distribution of land before the government and NGOs stepped in. Similar events occurred after the Mozambique refugees entered Malawi after the RENAMO insurgency of the 1980s. Further ideas on new settlement modelling were obtained from observation of how the rural Nyanja who left Malindi in the aftermath of the Cabinet Crisis (for political and land reasons) settled at Liwonde, Bilila, Sharpevale and Chipoka. In these settlements they either became incoming subjects or chose virgin land where they were more autonomous but still subject to local village headmen. For detailed information on these settlements I am grateful to the late Leonard Chipembere (Sharpevale) and the late Lester Lwanda (Bilila). These population movements, though vastly constrained, are still occurring. Recent 1990s movements include population movements, from the South, to Mchinji and the Northern region. For insights into these settlement patterns in Nkata Bay,

to re-construct a pre-colonial framework of health care.

In this context, workers like Phiri, K. (1975: 27), Kandawire, J. A. K. (n.d: 30) and Ross, K. R. (1996: 11) have already defended the use of oral data to recreate pre-colonial history in the context of Malawi. Oral historical sources are now accepted as useful in studying cultures, like Malawi, where the transmission of this type of data is established (Cormack, 1996: 119). Welling (2001: 15) has recently argued that historical archeology can contribute to some historiographic clarification of the oral narratives, particularly in terms of 'settlement, trade, and the "sacred"'. And in the wider African context some observers, like Ngugi wa Thiongo (1998: 108), while recognising the limitations of orature, see the privileging of written texts over oral texts in terms of power relations:

[It is more true than not] that the privileging of the written over the oral had roots in the relationship of power in society and history... The dominant social forces had become identified with the civilised and the written. With colonisation, the same binary opposition was transported to Africa, with the written and civilised being identified with Europe as a whole, the oral and the ahistorical being identified with Africa. The product of the oral no longer belonged to history because quite clearly the coloniser did not want the colonised to have any claims to history as a basis for their resistance and affirmation of their identity.

The subjectivity of colonial texts and the shortcomings of oral data were taken into consideration in constructing the chapter.⁵⁵

2.2 Background

The relationship between, among other variables, culture, social medicine and politics in Malawi and Africa has been noted (Mitchell, 1962: 57; Baker, 1975: 308 - 311; Vail and White, 1989: 151 - 192; Feierman and Janzen, 1992; Lwanda, 1993: 9 - 11; Vaughan, 1991: 23 - 26; Schoffeleers, 1997; Phiri K, 1998). Vaughan (1991: 23 - 26 and 200 - 206) and Butchart (1998: 181 - 185), though writing primarily about the colonial period, point to a relationship between socio-medical discourse and politics in the African context in general. Some (Chavunduka, 1973: 25 - 45; Hours, 1986: 41;

Mzimba, Mzuzu and Kasungu, I am grateful to Dr Austin Mkandawire (Mkandawire, Personal Communications, 1998 - 2001).

⁵⁵ An interesting example of how to strengthen the 'situational reliability of' oral data is given by Abdi (2001). He suggests interrogating the political and other motivations of oral informants.

Ciekawy et al, 1998) view traditional medicine in terms of power - socially healing, cohesive, accumulative or destructive.⁵⁶ Hours (1986: 41) asserts, for example, that 'African medicine is concerned with power'. And Chavunduka (1973: 43) found that [in urban Highfields, Zimbabwe] '... in the course of an illness individuals sought to find a social cause or meaning to their illness'. Or, as Geschiere (1997: 1 – 311) argues for the Cameroon, witchcraft is 'both a socially levelling and accumulative tool', ambiguously serving both disadvantaged poor and elites respectively.⁵⁷ Writing from a colonial and European viewpoint, Mitchell's (1952: 58) perspective is worth quoting:

The belief in sorcery [sic] is thus not only a causative principle but it interlocks with the moral code and the social structure... These beliefs are not held in isolation from the social system in which they live.

In all these works traditional medicine and allied cultural practices emerge as important pillars supporting various socially cohesive constructs. The argument beginning in this chapter holds that these constructs, inherited from pre-colonial traditions, even in transformation, renewal, re-invention or restoration, continue to inform indigenous attitudes to western medicine, particularly in the case of HIV/AIDS.

In this study, small pox and leprosy epidemics in the pre-colonial and colonial periods are taken as exemplars of the later postcolonial HIV/AIDS epidemic.⁵⁸ By examining the responses to medical and social illnesses/markers in the colonial period, we can demonstrate a pre-colonial framework of communal disease management.

This chapter, using some markers, reflects on traditional medicine's historical ability to treat and 'prevent', in the broad sense, illness, and takes a more robust and holistic view of traditional beliefs and medicine.⁵⁹ Using the examples of smallpox and leprosy it is suggested that this concept of public health extended to incurable diseases as well.

It should be noted here that traditional medicine had, and has, a purely medical [and surgical] dimension[s] or functions independent of the social dimensions (Johnston,

⁵⁶ In this case as a social construct.

⁵⁷ In this case witchcraft is viewed as a social construct.

⁵⁸ Because of the public perception of their infectiousness and the visible manifestations, social stigmata, morbidity and the need for social care.

⁵⁹ These include a 'classical disease', beliefs in *ufiti*, a manifestation of rheumatological symptoms, and a 'molecular scientific' disease.

1897: 439 - 452; Roles, 1966: 570 - 594; Werner, 1906: 80 - 81). Practitioners have used herbs, leaves, roots and fauna to effect treatments and cures for centuries. Some of these herbs have been validated as containing active pharmaceutical ingredients (Msonthi, 1982: 81 – 85; Morris, 1996).

In this study a number of markers are used to achieve continuity of analysis between the pre-colonial discourse and the colonial and postcolonial argument. Some were general markers chosen to illustrate the wider socio-cultural context within which western or formal education operates in Malawi and others reflect the general socio-cultural and socio-economic background. These markers, such as *ufiti* (witchcraft), poverty, class, wealth, issues of governance, *kukhwima* (fortification), heterosexual relations, family planning, traditional practitioners, the role of women, specific traditional practices, attitudes to condoms, some issues of socialisation, the persistence of the *mdulo* (sexual avoidance taboos) concept and other traditional cultural markers like scarification, are utilised to construct a framework of prevailing cultural attitudes.

Out of these five specific markers were used in the fieldwork questionnaires to represent the range of beliefs from the ‘scientific/western’ HIV/AIDS to the ‘traditional’ *ufiti*. These markers include: Malaria (*malungo*) a ‘classical disease’ (Karlen, 1995);⁶⁰ Rheumatism (*Nyamakazi*) a symptom of musculoskeletal disease;⁶¹ Fortification against disease, failure or enemies (*kukhwima*), a preventive power act;⁶² Witchcraft (*ufiti*); and HIV/AIDS (*Edzi*); a disease new to both traditions. *Nyamakazi* (rheumatism), with its ‘body pains’, ‘muscle pains’ and morning stiffness has all the hallmarks of a disease arising from a nocturnal ‘beating’ or ‘working over’ by *afiti* (witches).

Some of the general markers of *mdulo*, scarification, the role of women poverty/wealth, issues of governance, sexual relations, family planning, the role of *sing’angas* (traditional practitioners) and some specific traditional practices are also utilised in more specific contexts to permit better comparisons between different periods and

⁶⁰ A major public health problem associated with a validated cause.

⁶¹ *Nyamakazi* (rheumatism) = any painful disorder of joints, muscles or connective tissue. Chosen as a recognisable, if subjective, universal symptom.

⁶² *Kukhwima* (fortification) involves a belief (in the power of the process); the practice of undergoing fortification, usually involving scarification and some sacrifice; and finally, the continued belief in the power of the fortification to ward off disease, enemies and misfortune.

contexts, to give a more comprehensive picture, as well as to facilitate comparisons of the different public health systems constructed.

2.3 A brief pre-colonial cultural and political history of Malawi.

Despite the lack of written records, according to archaeological work by Tobias (1972) cultural remains in the Malawi territory were found dating back to the *Homo erectus* period. Clark's (1972) work confirmed this with findings of rock paintings and other cultural artefacts from 8000 BC.

A Southern African Bantu cultural context is supported by historical, linguistic and archaeological work (cf. Guthrie, 1967 - 1971). Cultural historical links between the Luba of the Democratic Republic of the Congo, Shona of Zimbabwe and the Chewa of Malawi can be traced using linguistic, oral and other evidence (Murdoch, 1959; Linden, 1972; Pachai, 1973: 1 – 4). This shared cultural heritage may partly derive from the presumed migration of the forebears of many of present day Malawians from present day Democratic Republic of the Congo between the thirteenth and sixteenth centuries.⁶³

The Maravi (Malawi) - Mang'anja, Chewa, Nyanja, Lomwe etc. - and Yao share similarities in their oral historical traditions, linguistic and settlement patterns, and some cultural practices (Nthara, 1973; Mitchell, 1956; K. Phiri, 1983; Schoffeleers, 1985).⁶⁴ In this context, it is possible to argue for the inclusion of the Yao, for most academic purposes, in the Maravi group.⁶⁵ Cultural similarities with the Ngoni (Thompson, 1995) are also noted. These cultural similarities include the Bantu

⁶³ According to Rangeley ([first published 1943 and reprinted] 2000: 8 - 9), between the 16th and 19th centuries, the 'Acewa' (Maravi) settled between Dwangwa River, to the north and the river Zambezi to the south.

⁶⁴ From linguistic, cultural practices like matrilineality, some oral historical evidence and other factors, it is possible to argue the case for the Yao inclusion in the Maravi cultural cluster.

⁶⁵ A significant difference between the Yao and the Maravi was the greater expertise for trade by the Yao. In the pre-colonial era, they had 'adopted a more complex economy long before the Whites came to Nyasaland [and occupied a role as] middlemen and traders' between the Arabs on the coast and the inland Africans, '[bartering] ivory, slaves, beeswax, and tobacco with the Arabs along the [coast] for guns, gunpowder, cloth and beads' (Mitchell, 1956: 17 – 18). Current historical explorations of Yao origins (Abdallah, 1919; Alpers, 1972; Bone, 2000) only trace the Yao as far back as Mozambique. My own observations suggest a significant number of shared linguistic markers between Kiganda and Yao, implying that the Yao may have arrived in Mozambique via the Great Lakes region. I am at present not aware of any work attempting to examine this theory, at least in Malawi.

language system and linguistic patterns, some mask dances' similarities, shared cultural artefacts, overlapping oral historical traditions and the rain cults systems (Cf. Schoffeleers et al, 1985; Schoffeleers, 1997).

Earlier Batwa and Akafula (circa 8000 BC) were nomads and hunter-gatherers. The later settlers to the area, the early Maravi/Bantu (3rd century AD – 11th century AD) were also nomads and hunter-gatherers. The later Maravi/Bantu (13th century – 16th century AD) were pastoralist, farmers as well as hunter-gatherers (Pachai, 1974: 2 – 9; Welling, 2001: 4 - 8).⁶⁶ Given their successive hunter-gatherer, nomadic, pastoral, and agricultural lifestyles we can argue that the pre-colonial culture, political, social and medical, of Maravi was significantly affected by the question of land (Pachai, 1975). The possession of adequate uncontested land tended to contribute to adequate food, better health and stability. Land contests produced conflicts. Legitimacy for land was based on '... conquest, first arrival ... ability [or] religious prowess to counter natural or supernatural hazards... (Pachai, 1975: 6).

The 'ownership' of land (*mwini wa dziko*), as now, was vested in the territorial religious and or secular head of the community, a communal rather than individualistic ownership (Rangeley, [first published 1943] and reprinted 2000: 9). Religious and cosmological ideas pertained to the rituals of harvesting, planting, births, puberty, deaths, prayers for rain etc., reflecting their dependence on nature. Inevitably, religious authority, held by mediums and practitioners, became intimately connected to the political authority it legitimised (Amanze, 1982: 37 - 50; Gaga, 1982: 61 - 63; Schoffeleers, 1979: 1 - 46). This intimacy shaped the evolution of complex socially formative and normative constructs, myths, beliefs, rituals and taboos integrating religious, economic, political and cultural elements. This is reflected in oral literatures and creation myths (cf. Mapanje et al, 1983) and traditions like *nyau* that contain many of these formative and normative elements (Kaspin, 1993: 34 – 37; Mwale, 1977; Schoffeleers, 1997: 9 - 12). These cultural constructs were designed to ensure stability. The examples in this work are mostly those of the Yao, Chewa, and Nyanja. The creation myths of the Maravi, for example, include that of *Kaphiri-Ntiwa* (the name of

⁶⁶ Welling (2001) has suggested that archaeology can clarify aspects of Malawi history circa 1500 – 1850 AD.

a hill), which ‘explains both how the world was created and how man’s wickedness led to God ‘being chased into the heavens’.⁶⁷

Among the Chewa, these myths and attendant rituals and dances, for example *gule wa mkulu* (the big dance) or *nyau*, contain elements of wisdom, cosmology, magic, religion and transition rites (Schoffeleers, 1997: 9 – 12; Kaspin, 1993: 34 – 57). For the purposes of our study, these elements and their evolution may give clues to the social and political dispensations then current in the pre-colonial era. Being agricultural and pastoral these communities therefore depended to a large extent on nature – weather, flora and fauna. It is easy too see why in their communities, chieftaincies and kingships, apart from land and its nurturing role involving food, farming or hunting, society was held together by religious and cosmological ideas pertaining to the rituals of, for example, harvesting, planting, births, puberty, deaths, and prayers for rain. Religious authority, held by mediums and other practitioners, was therefore intimately connected to the political authority it legitimised (Schoffeleers, 1997: 65). An example of this was the control of the rain making mediums by the chiefs.

The Maravi political or territorial legitimacy and control, as already pointed out, was predicated on primacy of claim, ability to make the land productive, ability to ward off hazards and the possession of religious power. This need for political authorities to control religious, economic, political and cultural elements led to the evolution of complex rituals, taboos and social constructs. This power, once established, could, as Thompson shows – in this case for the Ngoni - extend to other tribes (1995: 106 – 107). To ensure stability, and legitimacy, authorities needed to be able to claim the ability to intercede with the gods (Schoffeleers, 1972: 73 – 94; Amanze, 1982: 37 – 50; Gaga, 1982: 61 – 63). An example, of this legitimising of authority by the ‘ability to intercede

⁶⁷ According to this myth: *Chiuta* (God) came down with the first man and woman, landing on *Kaphiri-Ntiwa* hill, where the footsteps are still ‘visible’. God, man, woman and all animals lived in an idyllic world until man invented fire by rubbing together two sticks, setting the grassfire alight. In the confusion some animals sided with man, for example dogs and goats, while others, like elephants and lions, were furious with him. The chameleon tried to help God escape up a tree, but God was too old. The spider, seeing this, spun a web and lifted God up into the skies. Hence, God was driven from the earth by the wickedness of man (Schoffeleers and Roscoe, 1985: 19 –20). It is interesting that the chameleon, with its ability to change its external manifestation, appears in most of the creation myths in Yao and Nyanja.

with the gods', was also noted by Thompson for the Ngoni (1995: 51 – 53).⁶⁸

According to McCracken, the Maravi believed in first, the High God (*Chauta*) worshipped through territorial cults; second, Spirit (ancestral) worship; and third witchcraft.⁶⁹

...most people in the Malawi regions shared three basic religious beliefs: the first in the existence of witches, who were held to be responsible for otherwise unexplained misfortune, and who could be detected by doctors who frequently made use of *mwabvi* poison ordeal; the second in the spirits of the dead, who functioned as intermediaries between the living and the world beyond; and the third in a High God, worshipped through a number of large and influential territorial cults (McCracken, 1977: 42).

Van Breugel (2001: 267 – 272) gives a more comprehensive account of Chewa traditional religion. His account, in my view, is marred by the suggestion of Christianity influencing Chewa traditional religion (Van Breugel, 2001: 268); otherwise his accounts of *mdulo*, *ufiti*, *nyau*, initiation ceremonies and other practices are illuminating.⁷⁰ Breugel's accounts of the various aspects of Chewa religion and culture confirm the inter-relationship between religion, culture and aspects of governance. Thompson (1995) observed similar functional aspects of religious beliefs among the Ngoni:

...Ngoni religious rituals were closely integrated with the economic and political activity of the people in general. One of the major functions of such rituals was the well being of society as a whole. They were, therefore, often connected with important events and cycles in the life of the nation, and were carried out, for example, in times of drought, before hoeing, before harvest, and before going into battle (Thompson, 1995: 35 – 36).

This study does not regard witchcraft as a religion and (*vide infra*) sees witchcraft as originating from taboos that became corrupted. But if we accept Breugel and

⁶⁸ During a drought in 1885 – 1886, a time of early colonisation of Malawi, some traditional doctors (having themselves failed to make rain in the traditional Ngoni manner of cattle sacrifices) suggested that the drought had been caused by the Ngoni's 'refusal to listen to the missionary message'. Christian prayers led by Walter Elmslie, at the mission rather than at the traditional site for rainmaking ceremonies, were followed by rain at least twice (Thompson, 1995: 51 – 53). Whether this was a 'freak of nature' (Pachai, 1972: 197) or not, the missionaries were seen to usurp some of those traditionally legitimising powers the traditional Ngoni rainmakers previously had.

⁶⁹ The concept of witchcraft as religion is contested in this study. It is argued here that witchcraft has arisen from taboos and other constructs that became corrupted.

⁷⁰ I am grateful to J. C. Chakanza and J. Thompson for drawing my attention to current debates on Maravi religious beliefs.

McCracken's classification for the moment we note that disease causality theories mirrored this 'religious' trichotomy (Ntara, 1973; Morris, 1985: 14 – 36; Rangeley, 2000). It is worth noting, here, that the religious aspects and structures were only part of the picture. Malawians had a comprehensive medical service and were aware of diseases not caused by witchcraft (Feierman and Janzen, 1992: 214 - 215; Morris, 1985: 34 - 35). Johnston (1897: 439 - 452) observed:

The [Mang'anja] use many indigenous drugs, such as *Bobwana*, an anodyne; *Jigagaru*, a sedative; *Sabu*, a carminative; *Nsonga*, ... for the ears; *Petere*, 'good for asthma'; *Chisungwa* ... used as an emetic; *Mpiu*, ... used in child-birth; *Kanyanga*, ... for ... headaches; *Pichiru Maungu*, ... for pain; *Mobi*, for burns, and *Mlaza*, a sedative for mad people.

Werner (1906: 80 - 81), despite her colonial ethnocentrism, reluctantly paints a comprehensive medical service, complete with its 'private service':

... of *mankhwala* (medicine), variously translated 'medicine', or charms, and including what we understand by both terms... native doctors, both men and women, often have a very good knowledge of medicinal herbs, but it is the other kind of 'medicine' with which we have to do just now... (Werner, 1906: 80).⁷¹

Here, although she goes off into a discussion of 'offensive' and defensive' medicine, including witchcraft, she does give a picture of a comprehensive medical service.

It would be impossible to enumerate all the different varieties of "medicine". I believe there is some preventive of every ill likely to befall mankind ... and those who understand such things can do a profitable business (Werner, 1906: 81).⁷²

In relationship to 'the other kind of medicine', early colonial writers, including Werner (1906: 82), also noted, sometimes favourably, 'the ability to effect' the preventive

⁷¹ *Mankhwala* (medicine) has a much broader meaning than 'medicine' in western medicine, including herbs, lotions, potions, charms and all positive healing agents, as well as all paraphernalia of witchcraft.

⁷² Cf. the medicine man in J. P. Clark's (1964) *Song of a goat* who believes that for every ailment in man there is a leaf in the forest to cure it.

'fortification' (*kukhwima*).⁷³ Pre-colonial Malawi had the ability to recognise and treat malaria (*malungo*), as the 'fever' and *nyamakazi* (rheumatism) (King and King, 1992: 6). Early colonial medical personnel, like Drs Kerr Cross, Elmslie and, indeed, David Livingstone, noted, sometimes favourably, local medical skills (King et al, 1992: 23 – 24).

Yet, perhaps for reasons of ethnocentrism, sorcery and witchcraft discourses dominated colonial literature (cf. Parrinder, 1956: 142 - 150), (at the expense of the consideration of the other two belief systems, namely God and spirits), as negative forces that led to 'antisocial, nefarious acts'. The 'positive' and 'socially constructive' aspect of 'sorcery' (i.e. controlling mechanisms, via taboos) in pre-industrial societies was largely ignored.⁷⁴ Thus Ogungbemi (1992: 1 - 16), in an interesting discussion takes a 'modern and Christian' view and sees the influence of witchcraft on people, as 'fear' and 'superstition'. This stance fails to address the pre-colonial needs for societal controlling mechanisms. Yet, comparisons to modern governmental constructs, taboos, secrecy and control should be made.⁷⁵ A case for a pre-Foucault (1977) communal 'panopticism and disciplinary power' to aspects of sorcery and witchcraft can be made by substituting 'ability to observe' with 'ability to deter' (Cf. Foucault, 1977; Butchart, 1998: 28 – 31).⁷⁶ Mitchell (1952: 58), as we have noted had some insight into this 'cultural' power of traditional medicine. In postcolonial Malawi, witchcraft is still associated with misfortune (*tsoka*). *Kuliputa tsoka* (asking for it) alludes to the 'transgressive' element, and its in-built self-censorship, inherent in breaking a taboo. Pre-colonial witchcraft practices can be viewed as originating from socially positive taboos and medical practices that became corrupted. Bongmba (1988: 165 - 191) offers a useful hermeneutic of *Wimbum Tfu*, (a 'witchcraft' practice that can be negative or positive) using power, economic and religious discourse (Cf. Ciekawy and Geschiere, 1998). Given the 'corruptibility' in all three areas, we favour the concept of a negative practice arising from an original positive one (Cf. Geschiere, 1998: 1 – 14; Pels, 1998).

⁷³ Young (MNA S1/475/32) noted this for STD prevention among the Tumbuka.

⁷⁴ E.g. taboos designed to impose order.

⁷⁵ For example the roles of state security organisations and the various explicit, implied and imagined threats that go along with organisational or state security maintenance.

⁷⁶ In this case the ability to deter and detect taboo transgressors.

Territorial spirits were invoked in matters of 'communal interest, like droughts, plagues and epidemic diseases' (Feierman and Janzen 1992: 216). Appeals to territorial spirits involved sacrifices (*nsembe*). These 'resource' and 'ecological' aspects (Schoffeleers, 1979) are as relevant, if not more, in the post-HIV landscape, as they were in pre-colonial times. As authorities 'learned' to 'control' these epidemic diseases a political element to each ensued bringing the institutions of spirit worship, medical practice and aspects of sorcery under the control of kings, chiefs and other legitimated 'guardians of the land'. The political aspect of mediums is shown by fact that where chiefdoms collapsed spirit mediums assumed government functions (Amanze, 1982: 37 - 50).

Spirit guardians and medical practitioners were elites of society and used their positions and authority both for political and public health control. Public health control was achieved by: first, appeals to territorial spirits; second, public taboos and constructs, from which arose from corruption of elements of these, witchcraft and sorcery; and third, medical measures like variolation for smallpox (Waite, 1992: 215). To this list can be added, fourth, formative rituals, music and dances.

2.4 Sexual health and disease prevention

Taboos were important in sexual health. The concept of *Tsempho* ('bypassing')⁷⁷ or *mdulo* ('cutting') - sexual diseases caused by transgressing various sexual taboos via promiscuity, infidelity or sexual relations at prohibited or 'hot' times - is common in Maravi societies (Drake, 1976, Rangeley, 2000).⁷⁸ The prevention was clearly fidelity. According to Morris, an *Mdulo* or *Tsempho* patient evokes an HIV/AIDS victim:

⁷⁷ *Tsempho* results from 'violation of sexual restrictions; having extra-marital sex; promiscuity' and having sex with a woman who had a miscarriage (Kondowe et al 1999). Cf. Drake, 1976. *Tsempho* (bypassing) also denotes bypassing rules. *Tsempho*, *mdulo* and *kanyela* will be discussed in more detail in Chapter Five.

⁷⁸ *Mdulo* (cutting) implies the cutting short of someone's life by transgressing a taboo. *Mdulo* results from breaking codes of sexual behaviour, such as: having sex with a menstruating (*ali kumwezi*) or grieving (*ali kumabvuto* or *kumaliro*) woman before she has shaved, having sex with *azamba* (women who help at childbirth); having sex with one woman in the absence of the other (polygamous) wife; women putting salt into food while menstruating; parents having sex while the child is *wozizira* (cold) in the *chikuta* period (the neo-natal period, from birth to about four weeks); pregnancy prior to initiation among the Chewa. *Mdulo* is also held to be the result of witchcraft practices. The concept of protecting infants in the *chikuta* (neonatal) period shows that the Maravi had an empirical knowledge of neonatal susceptibility to infection. *Mdulo* taboos show some connectivity to preventive measures, all who came into contact with neonates had to be in the 'cold' (*ozizira*) state.

The patient becomes pale, ... hair loses pigment, he becomes thin and light, ... sometimes the body swells.

Unless treated, the patient ends up

vomiting blood followed by death (Morris, 1985: 29).

Contagious illnesses, like leprosy, associated with 'heat' were likely to 'infect' and heat others. Among Lower Shire peoples this was likely to happen. Prior to burial for example, dead lepers were hung from trees 'until they cooled' to prevent incurable disease spread (Rangeley, 2000: 26; Schoffeleers, personal communication, 2000). The leprosy skin manifestations (neuropathic ulcers, swollen tissues) signified 'heat'. In its skin manifestations, blisters, ulcers, swollen tissues, it has resonances with the latter AIDS manifestations of herpetic blisters and ulcers, skin ulcers and tumours and auto-amputation of digits. The 'hot' signs were part of the rationale for isolation, i.e. a public health measure.⁷⁹ This 'heat' resonates with the AIDS manifestations of shingles, skin ulcers and tumours.

The need to avoid close contact with people designated as being 'hot' is implicit in the construct, as are the public health elements.

The Maravi concept of disease prevention was, therefore, a mixture of morality, social and political engineering and religion - consistent with Hughes' (1963: 157) definition of public health as 'all illness that affects the public as well as all activity that it undertakes to influence its health status'. Given that 'public health is the meeting ground between politics and medicine' (Waite, 1992: 213), it is in the power and authority of this construct in dealing with epidemics and social order that we are interested. Thus smallpox outbreaks in pre-colonial Kenya could be caused by social reactions to famine: 'raiding, trading, migration, disruption of preventive variolation and the disruption of the traditional ceremonies to drive away epidemics' (Dawson, 1992: 93 - 97). A similar reaction was seen among the Maravi. One current traditional Chewa/Ngoni traditional song still echoes this pre-colonial public health and order

⁷⁹ Cf. the incineration of 'contaminated waste', shooting of cows suspected to have foot and mouth disease etc. in western human and veterinary medicine.

construct:

Balala! balala! (Scatter! scatter!)
mabvuto mbuyomo! (trouble follows behind!)
tiyeni tithawe! (let us all run away!).⁸⁰

To prevent *balala! balala!* authorities had to prevent or control epidemics. Significantly, in 1992 the (USA) National Institute of Medicine identified six similar major causes of disease emergence as: '*Breakdown of public health measures, economic development and land use, international travel and trade, technology and industry, human demographics and behaviour*' (Karlen, 1995: 217 - 218), and microbial adaptation and change. We note, therefore, that pre-colonial Malawi societies had, resulting from their historical experiences, measures for combating epidemics like smallpox (variolation, isolation, burial measures), rituals for leprosy, and measures to combat famine (migration). They also had medical practices to cope with 'every ill likely to befall mankind'; and used fortification (*kukhwima*) as preventive measures and 'witchcraft practices' (*ufiti*) both positively, as taboos and negatively in corrupted forms.

Of greater relevance to the thesis is the fact that they had taboos, like *mdulo* and *tsempho* for preventing sexually transmitted diseases. We have also noted the intimate connection between public health, political governance and religious activity.

2.5 Chapter Conclusion

This chapter suggests that pre-colonial Maravi had a traditional comprehensive framework of health care. This framework was intimately integrated with the religious, cultural and socio-political power systems and had arisen from their historical experiences and socio-economic circumstances. These measures, we have noted, were utilised to combat epidemics and famine. These epidemics and famine were sometimes solved by, there being no constraints to this, recourse to migration. They also had medical practices to cope with 'every ill likely to befall mankind'. And we have noted the intimate connection between public health, political governance and religious

⁸⁰ This song was later used by nationalists to warn colonial 'settlers' of their 'impending fate'.

activity; taboos and various practices helped maintain these. Given the success of the Maravi in establishing themselves in the Malawi region and the continuing recourse to and utility of aspects of this framework in rural areas it can be said to be efficacious in preventive and curative work. It could be argued, therefore, that it also has an inherent self-validating mechanism.

We have also noted the environmental aspect of these constructs, a reflection of the importance of the socio-economic ontology on social and medical epistemology.

CHAPTER THREE

3.1 A socio-cultural colonial history survey of Malawi.

Chapter methodology

This Chapter resulted from the historical use of data assembled as for Chapter Two. However, here, there was a greater use of oral sources. This chapter contains the colonial and post-colonial historical perspectives, including aspects of colonial western medicine, education and traditional culture in Malawi.

Using this data the development of Western medicine is critically analysed and contrasted with its linkage to, relationship to, differences with, and responsiveness to indigenous cultures within the cultural and political contexts of the colonial and postcolonial period. This Chapter suggests that

- Some cultural traditions previously practised at territorial (national/tribal) levels retreated into localities (village/area levels) as colonial power impacted on the nation/tribal level. Localised practices could be ‘invisible’ to the colonial gaze, minimising conflict.
- The colonial medical service evolved in such a manner as to promote the maintenance and/or parallel evolution of indigenous medical traditions among Africans, creating a duality.

Other factors favouring this duality included:

- Resilient indigenous cultures. It is here argued that the cultures had evolved around environmental, socio-economic, religious and power/knowledge frameworks appropriate to their locations. The attempt by colonialism to change these cultures without substituting alternative socio-economic and cultural alternatives was bound to fail.
- Limited African education. Universal African education was never achieved and

secondary education for Africans was only introduced in a limited manner in 1940. This limited opportunity for African secondary education was to lead to the creation of a small African elite that was, despite the delayed Africanisation (Short, 1974; Williams, 1978), to eventually supplant the colonial officials following independence.

- Malawi's rurality and colonial neglect. Malawi had no mines or factories to lead to the creation of an industrial base or other factors facilitating large scale urbanisation. Transport to, and communication with, the rural areas, from the few urban sites, was poor.
- The use of race as class descriptor facilitated the priority use of resources by the white colonialists at the expense of the African peasantry.
- The exclusion of Africans from decision making roles until independence (Baker, 1975)
- The colonial and postcolonial ambiguity towards traditional medicine.⁸¹
- The possibility that western medical education or training may only partially erase established cultural beliefs.

The present Chapter relates to Chapter Two by making the point that, due to the strength and appropriateness of the traditional framework, limited resources and other factors, neither the colonial nor the postcolonial dispensations abolished rural localised forms of this pre-colonial framework. These survive in rural and, in a muted form, in some urban localities.

3.1.1 The terrain of early conflicts

The cultural conflict between the indigenous and colonising cultures is characterised by an initial resistance by the host culture. This was followed by the development of a cultural duality with a persisting resistance and localisation as colonial power prevailed.

A discussion of the colonial experience of Malawi should perhaps include the effect of Islamic and Portuguese contact with the area. Pachai (1973: 41 - 60) briefly notes the Arab and Islamic influences from indirect contacts via coastal towns to nineteenth

⁸¹ Cf. Redmayne's (1970) account of Chikanga, the diviner, and his relationship with Dr. Banda.

century influences among the southern Yao and Nkhota Kota Chewa. Mitchell (1956: 139 – 140) notes the syncretism of Islamic practices with ‘ancestor cult worship’ to produce *sadaka*, as did ‘Islamic initiation ceremonies’ and Yao *lupanda* and *chiputu* rites of passage to produce the *unyago* (initiation) customs of *jando* (boys) and *nsondo* (girls).⁸²

The impact of Christianity and European culture on, and the resistance of, the indigenous cultures dominate the colonial phase.

Some observers have noted that, compared to Christianity, Islam achieved easier syncretism with Yao traditions (Alpers, 1972: 169 - 175; Bone, 1982: 126 – 138, and 2000; Msiska, 1995: 49 - 86). A number of reasons contributed to what was, in essence, an invitation of Islam into the Yao village (Msiska, 1995: 79 - 80). Christianity tried to abolish indigenous practices. Unlike the uninvited Christianity (which attempted to force its way in), Yao traditions, in their interactions with Islam, emerged supreme or little changed after the syncretism.⁸³ Further, Islam empowered the Yao both in their slave and other trade and in conflict with British colonialism and Christianity (McCracken, 1977: 6, 54 – 56 and 120; Alpers, 1973: 169 – 175; Bone, 1982: 126 – 138; Chakanza and Mijoga, 1996: 125 – 148).⁸⁴ The intense contests between Christians and rural Chewa (Linden and Linden, 1974) provide a contrast.

In the context of the HIV/AIDS debate, these cherished localised *unyago* rites are of relevance. When Yao chiefs succumbed to colonialism their communities split into smaller units (Mitchell, 1956: 2) or localities from where they resisted, by refusing Christian education for example, the ‘Christian cultural colonisation’ until after 1945.

⁸² Initiation rites involve the counselling of boys and girls by initiation rite elders (*anankungwi*) on following acceptable norms of behaviour. Initiation is the end of childhood and the start of adolescence or adulthood. Initiation rites are common in the matrilineal parts of Malawi, mostly the Central and Southern regions; but less common in the patrilineal Northern region. Some initiation ceremonies involve instructions in and the practice of sex before the end of the initiation camp (Munthali, personal communications, 2000; Cf. her PhD Thesis of the same year).

⁸³ For an account of Christianised initiation rites see an account by Lamburn (1991) included in Fiedler (1999: 178 – 213), and M680/30 Colonial Office Paper No. 65. In the Christianised rites ‘Local chiefs come from time to time to give instructions in the manners and customs of the tribe, the Christian teachers being present (but no European) to check any tendencies to teach unauthorised subjects’ (M680/30, page 96).

⁸⁴ As Yao and Islam made contact much earlier than did Christianity and the Yao, this is a comparative argument.

Small village units were crucial in resisting cultural change among the Maravi too. The loss of power by the Yao chiefs after the Protectorate was established confirmed their fears. Chiefs were central to the cohesion of their communities and under the security of colonialism villages and other larger communities split into smaller communities. The colonial governments attempt to control this by making chiefs 'people's representatives as well as government representatives' (Mitchell 1956: 37 - 45) led to further loss of the chiefs' traditional powers or as the *Annual Report on the Protectorate for 1912-13*, page 41, stated:

[the natives] who, finding themselves without the restraining influences to which their parents were subject, have of recent years evinced an inclination to emancipate themselves from the disciplinary responsibilities of village life and obedience to authority, and to adopt habits prejudicial to native family life.

Arab influence is seen by some observers also in the form of square houses, dress, nomenclature and Swahili words in the language. As will be discussed later, the preservation of some of the Yao rituals, particularly the *unyago* initiation rites of *jando* (for boys) and *nsondo* (for girls), is of interest to this study.

The Portuguese influence, via trade alliances and Catholic Christianity (Werner, 1906: 217 - 218; Pachai, 1972: 118 - 119 and 253 - 262; Mitchell, 1956: 22 - 24) with the Maravi and Zimbabwe chiefs, dating from the sixteenth century, failed to secure Malawi to the Portuguese east African empire, but, contrary to Feierman & Janzen (1992: 227) must have left some cultural influences, via the Catholicism, slave trade and the various alliances the Portuguese had with the Bantu (Johnston 1896: 55 - 61). The slave trade, which they enhanced, must have disrupted some of the social structures of the areas supplying the slaves. Some of the Yao and Lomwe migration into Malawi is blamed on 'Portuguese cruelty' (Mitchell: 1956: 59).

The Islamic and Portuguese impacts were followed by the Ngoni colonisation of Malawi territory, beginning in 1835. In the case of the Ngoni, power, territorial and cultural considerations were also noted (Thompson, 1995). If language and customs are used as criteria, the indigenous tribes sometimes fared better than the Ngoni colonizers.

David Livingstone entered Malawi in 1859 intending to open the area to 'Christianity and Commerce' (Ross A. C., 1996, 13 - 16). His efforts were followed, *inter alia*, by first, the establishment of the Anglican Mission at Magomero in 1861 (White, 1989), then second, the establishment of the Free Church of Scotland at Livingstonia, in 1875, and then the founding of the African Lakes Company in 1878. Inevitably, 'to protect the settlers', a British Protectorate was declared in 1891 (Ross, A. C., 1996: 13 - 16). The opposition of the African chiefs was overcome by persuasion or force as in the cases of Chiefs Mponda and Makanjira of Mangochi and Chikumbu of Mulanje (Pachai: 1973: 57). In the wake of the reality of the protectorate, more British settlers came to Malawi, appropriated much of the best arable land for tobacco, cotton or tea estates using African labour, some of it under *thangatha* (indentured labour) conditions (Kandawire, 1979).⁸⁵ Pachai gives a graphic illustration of the extent of the land appropriation:

By 1893 the land position in Malawi was as follows: one fifth belonged to ... the settlers and missionaries; one fifth to ... Rhodes' Company; one fifth... to the British Crown, and the final two fifths belonged to the Africans. ... Rhodes wanted to ... buy Crown and Africans' land leaving ... Africans in Malawi as tenants on their own lands, a frightening prospect.

For the Maravi, removing land from the control of the chiefs, as happened with the removal of economic power from the Yao chiefs, contributed to a diminution in the pre-colonial 'preventive medicine' structure. The removal of land rights in the rural areas removed many of the legitimising social constructs and upset local order. This, together with the suppression, or attempted suppression, of local customs was to contribute to conflict between the colonial regime and missionaries on one hand and the indigenous Africans on the other (Cf. Ross AC, 1996: 152 – 156).

The Africans only options were to work on estates, for Europeans as domestic servants or as petty government clerks and junior teachers. They were heavily taxed. Many were forced to migrate to South Africa and Rhodesia to work on the mines. Chiefs and those Africans who had embraced education complained of their second-class status. The

⁸⁵ A form of indentured labour system in which African communal land was sold to estate owners and the Africans became labourers/tenants tied to the new colonial landowners on the same land.

tensions between colonial power and culture, on the one hand and indigenous culture on the other were exacerbated by the impoverishing effect of colonialism, the exploitative *thangatha* (indentured labour system), the loss of power by chiefs and the constraints on traditional medical and cultural practices. These constraints on the traditional medical and cultural practices would be seen, given the public health role or social construct inherent in traditional medicine, as an attack on the very basis of Maravi culture.

Compounding the loss of land was the loss of African independent status and, in the case of the estates, village/area units. In these units the cultural restrictions were resisted; daytime village culture, suppressed by hard work and governance reasserted itself at night.⁸⁶ These constraints placed on traditional medical and cultural practices, given their social construction role, were, in effect, attacks on the very basis of Maravi culture. The removal of the legitimacy of land - hence economic power - from the chiefs threatened the pre-colonial 'preventive medicine' structures and upset local order. The 'guardians of the land' maintained their legitimacy by becoming protectors of culture, reflected in the intense conflict with colonialists. These early, rural led, anti-colonial resistances were for land and cultural rights (Cf. Linden and Linden, 1974).

3.1.2 Class, race and power

Conflict between western medicine and the indigenous culture was also coloured by racism predicated on European 'Darwinian assumptions' (Vaughan, 1991: 33). European 'individualism' and culture equated with 'civilisation', ignoring African concepts of *umuntu* (Musopole, 1996: 27).⁸⁷ Traditional medicine and cultural practices became significant parts of the resistance to colonialism and, later, to the postcolonial hegemony. This resistance in village localities, we argue, persists and, as we see later in Chapters Five and Six, promotes the survival of traditional medicine.

Given the colonial hegemony over governance, land, borders and travel, which reduced

⁸⁶ Memorably recorded in many missionary and colonial memoirs.

⁸⁷ Humanness or the concept of humanity as made up of the five essentials of form (*thupi*), spirit (*mzimu*), community (*mudzi*), integrity (*chilungamo*) and productivity (*nchito*). Humanisation occurs via social nurture or socialisation (*maleledwe*).

the ability of the traditional authorities to respond coherently over large areas to the colonial assault, responses became located, and continue to thrive, within village or area localities. Colonial borders prevented the traditional ultimate responses to political and socio-economic rupture – wholesale migration to new pastures. Since the erection of these colonial borders and constraints, the memorialised social experiences/responses of responding to invasion or cultural challenge could only be used from and within localised fragmented bases. These localised traditions were often invisible to the colonial authorities.⁸⁸ The permitted possible colonial migration – of male labour to other countries in Southern Africa - caused gender and other social tensions.⁸⁹ Kaspin (1993: 37) observes a similar phenomenon in her study of the Chewa *Nyau* culture:

While the political and economic authority of the chiefs diminished, the rituals of chief-ship re-emerged as a forum of rural resistance: *Nyau* became emblematic of African defiance against white rule. In this way *Nyau* detached itself from its moorings in the pre-colonial kingdom and reattached itself to the periphery: a sign of centralised power became a sign of decentralised opposition.

Some of the similarly localised resistance to western medicine erupts occasionally in regional or national '*mchape*' episodes or, as we see later in our examination of the Chilobwe Murders, coded political resistance.⁹⁰ It is not simply a colonial phenomenon.

The colonialists, though now in central control, also faced threats of their own. Disease epidemics threatened the colonial enterprise. As Vaughan (1991: 37) notes

⁸⁸ The localised nature of these practices can be seen from Rangeley's (2000) 1940s observation that 'It is surprising how few Europeans have heard even the name *mdulo*. It is seldom mentioned in discussions with Africans or appears in court records. Yet it is often present but inferred. For instance, a man may give as proof of the alleged adultery of his wife the fact that he challenged her to put salt in his *ndiwo* (relish). The court and every Mchewa know what that means, but very few Europeans know. Europeans know probably far less about *mankhwala* (medicine) including *ufiti* (witchcraft) and *mdulo* than anything else about the Achewa' (2000: 74 – 75).

⁸⁹ For example this worsens the male/sex ratio as males migrate to look for work. The worsening male/sex ratios tend to encourage the practice of polygamy, the possession of mistresses and extra-marital sex. The emigration of males to the mines, particularly South Africa, where the men were kept in dormitories with restricted access to females promoted a culture of 'situational' homosexual practices among some of these migrants.

⁹⁰ *Mchape* = 'the cleanser' – after the verb *kuchapa* (to wash), an herbal drink used by witch-finders, healers or opportunists. *Mchape* practitioners were convicted and sentenced to 'hard labour' prison terms. See for example Malawi National Archive (MNA): NS1/23/2.

Epidemics of smallpox, meningitis, of plague, and sleeping sickness posed a constant threat to the economic (and political) viability of the early colonial state.

The colonial response was to protect the Europeans, by spending more on their health, at the expense of the Africans (Baker 1975: 301). The Africans were either assumed to be able to cope using their traditional methods or simply disregarded. A similar reaction was later seen in the postcolony when Banda, having created the 'perfect well fed, stable and secure state' his government had to pretend they had adequate food resources even in the face of real famine' (Roe et al, 1989; Lwanda 1993: 193; O'Malley 1999: 134 - 136). For the colonialists then, as Vaughan observes above, these disease epidemics 'posed a constant threat to the economic (and political) viability of the early colonial state'. In responding by spending more on European health, at the expense of the Africans: western medicine became, and remains identified as *mankhwala achizungu* (European medicine), a phrase laden with racial and class overtones. The discourse from this era of *mankhwala achizungu* (European medicine) and *mankhwala achikuda* (African medicine) or *mtela wachiboyi* (servants' medicine) is still current. Where Africans could access western medicine the standards were often so bad that 'Africans of the better type [sic] flatly refused to enter the hospital' (Thomas, 1930).

We would suggest that, given the socio-cultural segregation between the Europeans and Africans in Malawi, both in rural and urban areas,⁹¹ the colonial experience was dealt with by the development of, or adoption of, a cultural duality rather than a true hybridity or cultural subjugation.⁹² Some of the core beliefs embedded in village localities were not significantly challenged by colonial or Christian assaults. This enabled many indigenous Africans to survive colonialism without experiencing Fanon's (1970) 'dissolution or fragmentation', perhaps a more common experience among the educated.⁹³ The latter have to confront the cultural dichotomy head-on.

In her work on Kenya, Shaw (1995: 1 - 27) has suggested that a sphere of 'colonial

⁹¹ Most of the African labourers lived in villages around, but very separate from, the estates or White urban areas (McCracken, 1998a: 247 - 269; Lamport-Stokes, 1989: 98; Mitchell, 1952: 51 - 58; Pachai, 1973: 278 - 303).

⁹² As used here, the Africans adopted different cultural behaviour patterns depending on the school, church, work, rural, urban or other context.

⁹³ Mental illnesses arising from cultural maladjustment have been described (Cf. Qureshi, 1989).

hybridity' resulted from colonialism there. While, with hindsight, there were influences in both directions, the early Malawi colonial experience was one of attitudes and practices being imposed from the coloniser onto the colonised. The work of Fanon and others, built on by Mudimbe (1989), Vaughan (1991), and others for example, suggests this interaction between indigenous culture and colonialisation led to the process of objectification and subjectification of the colonised.⁹⁴ Unlike Shaw's (1995: 1 - 27) Kenya, minimal 'colonial hybridity' resulted in Malawi; the colonial governance model was a paternalistic one intended to 'objectify and subjectify' (Fanon, 1970: 59 - 99) the colonised.

Colonial responses to epidemics were more 'governance' than 'medical', using smallpox police to enforced vaccination and eliciting resistance, 'evasion [and] concealment' of cases (Bevan-Pritchard, 1930). Lepers were isolated (King and King, 1992: 81).⁹⁵ These public health campaigns 'pathologised', 'objectified' and alienated Africans. Associated 'Christian' discourse regarded African beliefs and practices as 'ignorant' and immoral (Vaughan, 1991: 52). At Nkhoma Mission, for example,

...a strict racial separation was maintained... A moralistic of Church life... which condemned many African ways ... was characteristic (A. Ross, 1998: 194).

And Livingstonia, for example, aimed to

... teach the truths of the Gospel and the arts of civilised life to the natives... (Rotberg, 1966: 6).

Missionaries, perhaps, contributed more to the creation of dualities; the only way many African Christians could avoid cultural 'schizophrenia'.⁹⁶

⁹⁴ In the sense that the colonial experience was an attempt at both 'objectification' and 'subjectification' of the African body and mind. See for example Butchart (1998).

⁹⁵ There were leper colonies associated with the various missions. The funding for these was often inadequate. See MNA NZ1/5/1.

⁹⁶ With duality, one would follow Christian principles by day at the mission and follow traditional precepts at home/night.

But not all missionaries or colonial officers were ignorant of cultural factors. There was the occasional dissenting voice noted on the European side. For example, the acting Principal Medical Officer, in 1924, refused to sanction the prosecution of a traditional practitioner whose treatment had led to the death of a patient:

...I am in agreement with the opinion of the Hon. The Attorney General that it would be very unwise to prosecute a native doctor in a case such as the one referred to...

The case in question appears to have been entirely an accident arising in the course of a practice carried on in good faith and there is no suggestion that the drugs in question were administered out of any malice propense.

Certain patients are more sensitive to the action of certain drugs than others and causes of ill effects arising from such idiosyncrasy are not unknown in European medicine so we cannot expect not to find such cases occurring in native practice (MNA M2/5/14).

Although colonial medical practitioners tended to be ethnocentric in their views, Vaughan (1991: 29 - 36) considers that Drs Hugh Stannus and WT Berry, rather unusually for the time, noted culture as a factor in their colonial medical discourse. While Stannus linked his 'culture' to 'nature', Berry was aware of the different theories of causation held by Africans and 'attempted to provide cultural translation for the public health practices he was promoting'. So aware of this was he that he invented a 'local word for meningitis' when he was dealing with the epidemic (Vaughan 1991: 47 - 49).⁹⁷

In contrast, some Anglican missionaries, for example, sought to dislodge the traditional birth attendants from their hold on traditional society. In the process, in some rural poor areas, they almost succeeded in disrupting the age-old traditional birth attendant skills and their social functions. Significantly, this was attempted without providing adequate and sustainable alternatives. They not only could not provide comprehensive medical care but they also failed to recognise the role of poverty, industrialisation, migration and other colonial factors on their target populations - preferring to blame the African's 'Satanism', 'ignorance', 'superstition' and 'witchcraft' (Vaughan 1991: 55 - 76).

⁹⁷ *Mutu waukulu* (lit. severe headache), making meningitis the 'illness causing severe headache'.

3.1.3 Training of traditional practitioners

These colonial views disregarded the corpus of appropriate knowledge, which the traditional practitioners possessed (Cf. Morris, 1989: 34 - 54). Traditional practitioners were often thought of as charlatans. But as we saw in Chapter One, the usual modes of the training of traditional medical practitioners involve a number of steps: usually a calling, implied or via dreams; initiation into the practice; and finally a period of training into functions and malfunctions of the body, the use of medicines, divination, herbalism or other fields of traditional medicine as appropriate. This experiential training is combined with a clinical approach that gives psychological and social explanations for disease. Given the limited health education in colonial times, traditional practitioners were usually better at offering disease explanations to the public.

3.1.4 Health education and dialogue

In this Chapter, for space constraints, the history of the government medical services, rather than both government and missionary services, is used to illustrate the colonial encounters and interactions between western medicine and traditional medicine.

The theme of rural neglect can be found in Malawi's colonial and postcolonial medical history. For example, Baker (1975: 301) in his usually understated account of the history of the government medical services in Malawi confirms as much:

Until the early 1920s the medical service was designed primarily to care for government officials. This was clearly stated in Dr Boyce's 1891 contract and remained the case for thirty years. Government hospitals were located where government officials were stationed and not where the bulk of the population lived.... But the influence of the [First World] War was not sufficient in itself to induce what was, in essence, a considerable shift in policy, a shift towards social service as part of government's function, a move away from 'law and order' administration towards development, a reorientation from focusing on the official

element towards providing facilities for the African public.

Colonial Malawi was, as is postcolonial Malawi, certainly dogged by its poverty (Pachai, 1972), the major reason given for the poor health facilities. By 1911, there were only 3 African hospitals and 2 dispensaries, rising to 44 dispensaries in 1922 (Stevenson, 1964: 14). Yet, even if we accept the fact of the poverty, were available resources applied universally? Baker provides the answer that they were not. Even after the Second World War, the expected post war pressure for and provision of more government health services for Africans did not materialize; the African voices led by Levi Mumba⁹⁸ and others were too weak. It is useful here, then, to ask: What medical facilities were the Africans using in this period? There were missionary medical services, which had followed the expeditions of David Livingstone (Gelfand, 1957) but these missionary services did not make much impact on the African population either until about 1910. Without labouring the point, until the missionary network had become established, and the government medical services become more egalitarian, particularly after the Second World War, many Africans continued to rely on traditional medicine.

A number of factors were responsible for this state of affairs. Firstly, the missionary and government doctors were busy attending to the health needs of the European missionaries and settlers (Baker, 1975: 301). As already seen, the economic and administrative imperatives directed a bigger share of hospital resources towards government officials and carriers. Second, was the fact that '... in the early days although a lot was already known about European concepts of disease causation, the services on offer were largely curative' (Baker, 1975: 310). Thus there was little early preventive medicine. In other words, to Africans, from a distance and at a personal phenomenological level, western medicine appeared to have the same characteristics as traditional medicine; the rituals of history taking, diagnosis and treatment, but lacking the psycho-social and religious depth of traditional medicine. And the little colonial preventive medicine on show, namely smallpox campaigns and leprosy, for example tended to confirm known features of African causality in their hut destruction (smallpox) and isolation of patients (leprosy) respectively. Third, the rurality and poor

⁹⁸ The coordinator of the native associations in the 1920s and 1930s whose work (with Frederick Sangala and others) and vision led to the formation of the Nyasaland African Congress on 20th May 1944. Cf. Letter (Mumba, L to Sangala, J. F., 16/10/43) in MNA60/HKB/1/1/1(b).

infrastructure of Malawi, kept much of Malawi closed to direct, as opposed to secondary, missionary influence. Fourth, the limited educational opportunities and constrained roles of Africans retarded the early development of a significant African elite. There was thus only a mild voice demanding better western medical services. But to their credit, Missionaries provided the early medical training in Malawi, with government training only commencing in 1930 (Stevenson, 1964: 15). Yet even the medical and paramedical training also showed the conflicts at play.

Medical training

One of the causes of the delay in dialogue between western medicine and traditional medicine is fact that there were, until after 1952, few African doctors or senior medical assistants. The colonial government was reluctant to train African doctors. Up to the establishment of Federal Government in 1953, no single African doctor, nursing sister, health inspector or other senior professional cadres had been trained or employed by the colonial government. Indeed, the *Nyasaland Protectorate Development Programme* (NPDP) for 1948 finds it 'necessary to train Africans in increasing numbers as health assistants, medical assistants, midwives, sanitary assistants...' (NPDP, 1948:18 - 19). On the other hand, more European doctors were being recruited. 'Among additional non-African staff provided under the plan are 8 medical officers' (NPDP 1948: 18 - 19). The honour of the first Malawi 'western trained medicine man' must go to John Gray Kufa.

But Kufa's acceptance into the Scottish medical and church milieu was, however, not total; while the missionaries had sought to give him a new identity the subjectification was not complete. The high praise and trust from the missionaries did not equate with total acceptance, perhaps to 'doctor' level'. Shepperson and Price (1987: 242) are wrong to consider men like Gray Kufa, 'marginal men'.⁹⁹ We would consider that these were pioneers whose examples shaped the medical traditions to follow. Far from being 'marginal', he appeared to have attained some understanding of the new western

⁹⁹ The Shepperson and Price's *Independent African* was originally published in 1958. The page numbers used in this work are those found in the 1987 version. I am grateful to Professor George Shepperson for a signed copy of this later edition.

culture. Kufa's own quest for an identity, one that gave him full equality with his White compatriots, was to lead him into another direction.¹⁰⁰ This was towards a personal and ideological friendship with John Chilembwe, who led the Nationalist uprising of 1915. Here we note the duality of his existence: an exemplary medical man, church elder, but also friend and deputy of the nationalist John Chilembwe. Thus, even before the first proper medical doctor had graduated, the colonial Missionary model of an educated African medic had been found wanting by their most successful product. The *Nyasaland Times* of 4 February 1915, though crudely put, illustrates the cultural and expectation gap:

In a sense all Missions are responsible as [the Rising] is due to the effect of ill-digested teaching on the native mind ... it is very plain that to educate natives very highly and then not find suitable employment for them is a mistake (Shepperson and Price, 1987: 363).¹⁰¹

Dr Daniel Malekebu was the first Malawian medical graduate. A tantalising set of letters between Banda and Malekebu illustrates the different motivations and personalities between these two, and also gives a sketch of his life and treatment by the colonial authorities. The background to the letters is the marginalisation of both men by the colonial system and their previous impotence, an impotence dealt with in different ways by each. In a letter to Dr Banda, who had accused him of not being nationalistic, Malekebu tells of his

¹⁰⁰ Originally from Zambezia, in modern day Mozambique, though not a qualified doctor, he was '... the first African to get 90% marks in the special Blantyre surgical examination, and was looked on as the prototype of the African doctor, the fruit of the care and skill of Scottish Kirk and medical school overseas' (Shepperson and Price 1987: 85). DC Scott, a Presbyterian missionary, considered that: 'JG is an ideal man, not an ideal mission product or an ideal African' (Ross, 1996: 125). Kufa, baptised in 1890, was ordained a deacon in 1892. He was one 'of their ablest converts' (Shepperson and Price, 1987: 59). Kufa, who graduated as a medical assistant in 1898, was '... clearly marked out as the next thing to an African doctor in the Protectorate. Work in school and church, and proficiency in medicine approved by the Scottish doctors with their high standards, gave him a position of special trust in the Blantyre mission. He was soon the foremost native assistant in its hospital and was entrusted with work in the dispensary. On the eve of the rising he was an elder in the Blantyre Church (Shepperson and Price, 1987: 243). Kufa worked, as a hospital dispenser, at the Bruce Estates at Magomero, notorious for its exploitative *thangatha* (labour rent system) and where working conditions for Africans were poor (Shepperson and Price 1987: 178 - 182).

¹⁰¹ A report into the Chilembwe rising blamed the Scottish and Protestant missions essentially for educating the Africans and insisted that African teachers and leaders could not be trusted; the Roman Catholic and Anglican missions' methods of 'supervising their African students being exempt from this criticism' (Shepperson and Price 1987: pages 368 - 396 and 363 - 396; and Ross, AC 1996: 190).

... vision of going to America, of which I had heard so much talk about, to be educated as a minister, a teacher and doctor of medicine, to return to Africa and build a church, school and hospital to help my people (Malekebu to Banda, 27/12/62).

Although the social forces opposing this are not enumerated he admits that he had to 'run away from my people (ibid, 1962)'.¹⁰²

Malekebu's first return to Malawi was to be aborted in 1920, in the wake of the 1915 Chilembwe rising, after the Governor turned him back at Port Herald. His vision thwarted, he spent 9 months in Cape Town, and nearly four years at Ricks Institute in Liberia, a school 'which had been in need of someone to lead it' (ibid, 1962).

Finally, after the dust of Chilembwe's rising had settled,¹⁰³ he was allowed back into Malawi in 1925, only to face the backlash of his own people who, in his own words, initially thought of him as [another?] 'trouble maker'. Of his own outlook Malekebu writes:

My life has been dedicated to the services of my people from the beginning and it is impossible for me to be otherwise... I could never think of interfering with [sic] freedom of other people to meet freely and worship freely. Certainly I would not like for others to deny me, or our people, to do the same... I am asking to be judged not by what I have not said, but examine what I have tried to do for the advancement of our people and country. My work is a national one; my organisation is national (Malekebu to Banda, 27/12/62).

For Malekebu then, and later for others, medicine was a route to self-empowerment in order to be in a position to 'help [his] people'. His outlook was that of leading by example, eschewing outright politics.

¹⁰² If we regard Kufa as a 'doctor', Malekebu and Banda would form the 'second wave'. Malekebu was a student of the Providence Industrial Mission, which had been established in 1900 by John Chilembwe. A former Afro-American Missionary, Emma B. Delany, to whom he had been a houseboy, and presumably from whom Malekebu had accepted Christianity, had taken him to America in 1907. Malekebu graduated from Meharry Medical College in the USA in 1917, and then took Bible Studies at Moody Bible Institute in Chicago (Shepperson and Price 1958: 412). He married an American wife and became '[ordained] to the gospel ministry [before turning his mind] to Africa after the cry of a few of our people who needed a leader to reopen the dead, but not buried Providence Industrial Mission' (Malekebu to Banda, 1962). I am grateful to Rodney Orr for copies of the letters, and to Jack Thompson for drawing my attention to these letters.

¹⁰³ John Chilembwe the founder of the Providence Industrial Mission led an uprising in 1915, which resulted from grievances about land and political and cultural rights. See Shepperson and Price 1958: 218-263 for a comprehensive account.

But this was a political decision, if leading 'by example' is an adequate clue. It could be that his views had been shaped both by Chilembwe's rebellion - which turned him towards collective advancement through education, hard work and Christianity - avoiding direct confrontation, as well as his disinclination to 'seek personal glory'. The fact that he hardly practised medicine in Malawi supports the contention that he later may have used his qualification as a symbol of empowerment.¹⁰⁴ Banda on the other hand was a much more complicated personality. His life charts frequent identity and personality changes. The self-improvement imperative led him, at age 17, to S Rhodesia, then to South Africa.

In 1925 he travelled to America. He studied at the Wilberforce Institute (Ohio), Chicago University and finally at Meharry Medical College in Tennessee, graduating in 1937. That year, he sailed for Scotland to obtain British licentiates, required for work in the colonial medical service.

He entered general practice after both the colonial government and Scottish missionaries made it impossible for the proud Banda to return home 'as a full doctor'. Thus far Banda's identity fits that of a highly motivated young man eager to educate himself in order to be of service to his people. Banda's rejection by the system he tried to join was double.¹⁰⁵ In 1941

A group of nurses at Livingstonia wrote to the Church's headquarters in Edinburgh to say they would not be prepared to serve under an African doctor. Banda took this blow with remarkable calm. 'I'm glad they said it now,' he confided to friends. 'If I'd gone and found out there, how embarrassing it would have been.' But beneath his stoicism he was bitterly disappointed (Short, 1974: 39 - 40).

He received the next rejection from the Nyasaland government

¹⁰⁴ Other busy doctors, such as David Livingstone, Robert Laws and Kamuzu Banda practiced some medicine.

¹⁰⁵ Born in 1898, Dr Hastings K Banda was, remarkably, during his life a pupil teacher, oiler, mineworker, clerk, and interpreter, doctor, general practitioner, politician. Though later baptised into the Presbyterian Church as Hastings, his original name Kamuzu (a little root) attests to herbal help in his conception (Short 1974: 6). Influenced by his uncle, Hanock Phiri (himself a Livingstonia Institute graduate) in the customary Chewa manner, Banda underwent the Chewa tribe's *Vinyau* ceremony. During Livingstonia entrance exams, the diminutive Banda craned at the board over a taller man and the strict Rev Cullen Young dismissed him from the exams. His later achievements - Banda would later co-author, with Young, *Our African Way of Life* (1946) - tend to counter any charges of cheating.

There was an argument over whether he should be paid as much as a European; over whether he was to be allowed to treat white patients; over whether he could use the newly built Zomba swimming pool; over where he should live, and a hundred similar points. Eventually he was offered a job... But soon a letter arrived from the Colonial Office informing him [of an extra condition]: he must undertake not to seek social contacts with white doctors (Short, 1974: 40).

Here the race as class descriptor or signifier was clearly spelled out. Yuval-Davis, for example, sees

racist discourse as involving the use of ethnic categorisations ... as signifiers of a fixed, deterministic genealogical difference of 'the Other'. [With this] Otherness [serving] as a basis for legitimising exclusion and/or subordination and/or exploitation of the members of the collectivity thus labelled (Werbner, P. and Modood, 1997: 193).¹⁰⁶

Writing about his life, spanning the 1940s to the 2000s, Austin Mkandawire gives a sustained and vivid account of the frustrations of being a hospital assistant, alluding to the then current conceptions that Africans could only rise to be hospital assistants.¹⁰⁷ In Mkandawire's autobiography the factor of race as a class descriptor is more apparent (Mkandawire, 1998: 31, 57, 71 - 73, 79). Mkandawire gives an illuminating example of colonial subjectivity and objectivity.

¹⁰⁶ I am grateful to Paul Nugent for drawing my attention to a number of conferences and seminars dealing with the subject of identities.

¹⁰⁷ Mkandawire, who was born in 1931, straddles the colonial and postcolonial medical terrain in more ways than one. His maternal grandfather, Yuria Chirwa, baptised in 1889, became, after training at Lovedale, one of 'Dr Laws closest and most trusted companions (Mkandawire 1998: 9 - 10)'. Mkandawire had a traditional – in the 'rural' sense - upbringing, despite the early church connections: 'Village life is a learning institution for most African children. It is an education, which must be experienced by every growing child... You learn the art of socialising, the spirit of give and take and the rudiments of community living (Mkandawire 1998: 16)'. After education at Livingstonia, and failing to secure a place at Blantyre Secondary School, he entered the hospital assistants' course in Zomba in 1949, a three year course that included chemistry, pharmacy, biology, anatomy, physiology, materia medica and therapeutics, surgery, pathology and bacteriology, toxicology, public health, medical jurisprudence and medicine as instituted under section 10 of the Medical Practitioners and Dental Ordinance (No 6 of 1926) which grouped [African] Hospital Assistants and Non-European or Indian doctors in its 'Sub-Register' (Mkandawire 1997: 82 - 86). At the Zomba Hospital training school Mkandawire recalls being trained by ex-Livingstonia and Blantyre mission hospital assistants. Mkandawire survived and provides 'excellent clinical and administrative services' to this day. He was involved in advising the Traditional Herbalists' Association to change its name to Mediciners Association of Central Africa (MACA), to emphasise their role as herbalists who are 'rational healers' Morris (1985: 39). Mkandawire is comfortable with "'orthodox or conventional" traditional medicine properly licensed, using tried and tested herbs, co-operating actively with western medicine', but draws a line at witchcraft and divination (Personal Communication, Mkandawire, 15/7/01).

We, the Africans, were not allowed to have a break during [theatre] cases; there was always something to do for the next case. The Europeans would dash to their offices to have tea or refreshments. Since the theatre did not have a toilet, Andrew Chipole, who was confined to theatre during the whole list of operations, often had to urinate in the sluice to relieve himself. He was scared to tell either sister or Mr. Roberts about his discomfort or this imposed inconvenience (Mkandawire, 1998: 57).

Mkandawire also tells of being 'kicked [in the] ribs' (Mkandawire, 1998: 57) after he had given the 'wrong shoes to Mr. Roberts'; of white doctors cruelty to their staff including ordering a hospital assistant suffering from pneumonia to work (Mkandawire, 1998: 71-73); the operation of a colour bar (Mkandawire, 1998: 78-79 & 85-86); and of the colonial medical officials' systematic attempts to thwart his quest to become a doctor and not a mere hospital assistant. Mkandawire persevered. After working as a hospital assistant he eventually went to the UK and Ireland for secondary and university education, returning home in 1971. His experience confirmed McCracken's assertion, and Malekebu's experience, that during the colonial era, education was a means of social differentiation (McCracken, 1977: 294).

Thus despite the achievement of education, a factor of social differentiation, Africans in Malawi, as in East Africa (Iliffe, 1999) still had to fight to be given the professional status that went with the qualifications. It should be noted that in colonial Malawi Asian doctors were also placed in a class below white doctors.

Interestingly, on his return to Malawi, Mkandawire found that Dr Banda, his teenage years' hero, kept him working unpaid because his [Banda's] security agents had not security 'cleared him'. In 1971, Dr Banda, now the 'oppressive power', did not appear to like other African doctors and Mkandawire was 'subject' to all the deprivations typical of a colonial state for an African. In fact Dr Banda went further. A number of senior hospital assistants, including Drs Lungu and Thindwa, were sent to France for medical training in 1966. On their graduation, Dr Banda colluded with the French authorities to deny them the residency year experience, which would have made them 'full international doctors'. Although qualified in every academic way, without the full

French certificates, they remained little different from Gray Kufa in status.

It is understandable that Banda, Kufa and other early African medical personnel thus subjected to both universalist and cultural racism sought refuge in their own strategies of coping, strategies of self-liberation. We can (Werbner and Modood), 1997) differentiate between universalist and inferiorising on one hand from cultural and differentialist racism on the other. Kufa, despite continuing to be an efficient uncomplaining clinician, quietly joined Chilembwe's nationalist uprising abandoning all; he was executed after the rebellion. Malekebu, all but abandoned medicine and became a successful mission administrator. And Banda was later to use aspects of the western culture he had appropriated, mixed with his version of African culture in general and Chewa culture specifically, to produce a virtual replica of the colonial era with himself as the *bwana mkubwa* (governor-general). We noted how Dr Banda used cultural symbolisms from both the West and Malawi.¹⁰⁸ In the current context it is important to note the duality of his persona - the highly educated western-trained doctor versus his *Kamuzu*¹⁰⁹ persona, with all its herbal connotations.

The first 'third wave' Malawi doctor, SV Bhima returned in 1952, after training at Makerere (Mkandawire, 1998: 52). The fourth wave of returning doctors, in 1960-61 comprised Harry Bwanausi, Anne Ascroft and Vidah Ngwira. Class (ability to afford the costs) enabled some of these early doctors to go to university. There were only three Malawian doctors in government service in 1962; by 1964 two others Y.H. Misomali and D. Chilemba had returned (*Nyasaland (Malawi) Development Plan 1962-65: 39*).¹¹⁰ Until the return of these four in the decade between 1952 and 1962, Malawi Africans had been restricted to 'health, medical, midwifery and sanitary assistant roles...' (Stevenson, 1964), delaying the possibility of an epistemological dialogue between traditional and western medicine.

Only five doctors were in post at independence. This marginalisation of Africans

¹⁰⁸ Malawi chiefs called Banda *bwana mkubwa*. See Vail and White (1989: 151-192); Lwanda (1993: 11); Kaspin (1993: 49-53); and Forster (1994: 489-492) for cultural aspects of Banda's regime.

¹⁰⁹ *Kamuzu* = a small root in Chewa.

¹¹⁰ Bwanausi and Ngwira were both to be exiled soon after independence, in 1964, after disagreements with Dr Banda.

spawned a precedent that saw some doctors use professional medicine as a tool of self-improvement (Lwanda 1999). In the face of racial (colonial) and political (postcolonial) repression, qualifications, which ensured status and world or regional exportable skills, became desirable and attractive to secondary students.

In these busy roles, as over-worked medical assistants and nurses, the Africans were unlikely to begin the task of addressing the epistemological differences between western and indigenous medicine. Their limited education was another significant limiting factor; secondary education was only introduced to Malawi in 1940 (Banda, 1982; Mkandawire, 1998: 23).

The marginalisation of these early African workers to manual roles, the restriction of services by race, and the impression given that even these second rate services were primarily for elites would confirm the perceptions of those Africans who saw *mthengo mdalaka njoka* (the forest defeated the snake, in the sense of ‘east is east and west is west’ and the two will never meet) at play.

This attempted imposition of a colonial epistemology on an incompatible indigenous ontology was an exemplar for the later HIV/AIDS discourse that ignored the realities of rural Malawi. While, there was some limited health education conducted by medical assistants, secondary schools, mission hospitals and other agencies, these were not adequate to make significant inroads into localized traditional practices. The health education in schools was designed to be

... taught practically, in way that will enable pupils to apply their knowledge afterwards in their own villages (MNA M2/24/37).

Significantly, as we see later, there was recognition that this [the schools practical hygiene lessons] can only be done ‘with the approval of, and in collaboration with, the local authority (MNA M2/24/37)’.

At the end of the colonial era, the abiding strength of the Malawian traditional medical system, were, as elsewhere in colonial Africa, major factors in their survival (Feierman,

1985: 73 - 147). Some of these strengths arise from the conjunction of medicine and politics with religion in Maravi and Yao societies. While appropriating some of the more useful and colourful aspects of western medicine, addressing new threats and diseases and spawning peripheral hybridities in the process, traditional medicine at its core has not changed fundamentally during the colonial period (Cf. Vaughan 1991: 23 - 26). This process was facilitated by the fact that those key 'marginal' men who could have been influential, and better placed to challenge the hold of indigenous medicine on the African population in the epistemological dialogue between traditional medicine and western medicine, were indeed marginalized. There is also the contestable, but in the long run, sustainable, notion that colonialism was but a brief insult on some indigenous cultures. This notion of a brief insult can be justified from the chronological point of view if one considers the length of the pre-colonial phase. It can, as has begun to be apparent, also be advanced from a medical and demographic point of view. On the South African 'John Webb Talk Show' on 1/7/2001, Nikiwe Bikisha, a Xhosa 702 Radio reporter, in a discussion on HIV/AIDS posited that 'AIDS is/will be bigger than colonialism'. Clearly it will, within the next decade become clear whether that is an exaggeration or an accurate prophecy.

In effect then, from the arrival of Livingstone in 1859 until 1914, Africans a) continued to rely largely on traditional medicine and b) received some limited medical services from government and missionary personnel.

And between the First and Second World wars, although progress was made, it was not enough to affect the rural areas significantly. Even as late as 1946, health education was a limited concept in Malawi. That year, a government health official wrote that there were:

... no organisations in Nyasaland whose whole efforts are directed to health education. However [the various churches] engage in health education through their schools... Hygiene is taught and [special emphasis] laid on the prevention of such common diseases of the country as malaria, hookworm, bilharzias, and the dysenteries...

In larger centres [medical officers] conduct a series of lectures on hygiene annually

The following government pamphlets are available for free issue to Missions and other bodies:

Venereal Disease (VD) [Sexually Transmitted Diseases, STDs] – 2

pamphlets

Malaria

Rat destruction and plague

A simple type of septic tank

Cerebro-spinal fever

Tuberculosis

Courses are given [by the medical department] to Native Authorities, headmen and their wives [selected each year to attend the Jeanes Centre]

As all missions engaged in teaching receive grants from Government it may be said that health education is sponsored by the government (MNA/Miscellaneous file No. 505).

I argue that, in rural and peri-urban areas, given the cultural segregation (McCracken, 1998a: 247 - 269), the conflict between Christianity and western medicine on one hand, and African Traditional Religion (ATR) and traditional medicine on the other, was resolved by the development of or adoption of cultural dualities rather than hybridities or cultural subjugation. Many core cultural beliefs, now embedded in village localities, were not significantly challenged by colonial or Christian assaults; they had been placed out of the colonial gaze. This invisibility often gave the impression of, and was mistaken for, indigenous practices dying out under the overwhelming and inhibitory nature of colonial governance. Dualism enabled many Maravi to survive colonialism without experiencing 'dissolution or fragmentation'¹¹¹ (Fanon, 1970: 7 and 77) a more common experience among educated elite who, unlike the more culturally secure villagers, had to confront the cultural dichotomy head-on.

In the area of medical training and education, the colonial authorities hardly addressed the epistemological differences between western and indigenous medicine. And neither did the first postcolonial regime. The limited education was a significant limiting factor; secondary education was only introduced to Malawi in 1940 (Banda, K. N., 1982; Mkandawire, 1998: 23).

In conclusion then, the marginalisation of early African medical workers to manual roles, the designation of service requirements by race, and the impression given that even these second rate services were primarily for African elites served to marginalize rural Africans from western medical culture. It also delayed epistemological dialogue

¹¹¹ Mental illnesses resulting from cultural alienation or maladjustment.

between traditional and western medicine.

3.1.5 Nationalism, medicine and culture

The nationalist struggles, from the native associations, ca. 1912, through to 1964, could be viewed against this background.¹¹² Some educated Africans, many Christian, were not necessarily for a return to African traditional beliefs and practices; they were after economic and political power (Shepperson and Price, 1958; Rotberg, 1966). A similar phenomenon was seen after Malawian nationalists took over power from the British. Class, rather than race became an issue. Some nationalist politicians wanted to reduce the power of the chiefs further, in the interests of 'modernity' (Chisiza, 1961), a conflict that remains unresolved.¹¹³ In the postcolony, politicians still recognise chiefs as guardians of the land (Kishindo, 1994: 57 - 66), a recognition tinged with envy. The educated nationalist elite mobilised rural masses, playing to the latter's cultural, economic and political expectations, but without conceding a post-colonial 'cultural renaissance'.¹¹⁴ The 'elite' used class just as the whites had used race before them.

Comaroff's (1982) contention that biomedicine's epistemology is [to an extent] a 'cultural construct' has some resonances with how politicians, colonial or postcolonial, view traditional and orthodox medicine; they are constructs that serve national or social purposes.¹¹⁵ In times of illness individual helplessness leads to loss of control and alienation (ibid: 57). This submission to helplessness, which can be politically or otherwise exploited, is a universal phenomenon, found in European welfare states and

¹¹² John Chilembwe's anti-colonial uprising, in 1915, resulted from land, political, and cultural/religious grievances.

¹¹³ In Malawi the issue of the power of the chiefs is intimately related to the balance between local and central government. Under the 'Independence' (1964) and 'multi-party' (1994 and 1995) Constitutions the chiefs are part of the local government structure. President Muluzi's regime frustrated the resurgence of powerful chiefs by firstly delaying local government, and then thwarting the establishment of a senate. In the senate, designed as a counter to prevent Parliamentary excesses, chiefs would have had a significant role.

¹¹⁴ Apart from a few, like Nyerere's proletarian *ujamaa* project, most of the postcolonial renaissance projects, including Thabo Mbeki's are elite grounded.

¹¹⁵ This exploitation is also found in European countries. Cf. the nationalist discourse that surrounded the British National Health Service (NHS) between 1970 and 2000. This discourse succeeded in persuading most Britons that the National Health Service was the best in the world despite growing evidence to the contrary. It was not until 17/4/02 that the British Government admitted that it required a 43% increase in real terms to bring it to European levels by the year 2007 (See Catherine MacLeod 'Brown's NHS tax gamble', *The Herald* (Glasgow) April 18th 2003).

Malawian extended family contexts. In either context an individual may submit to the care of the appropriate service, in the form of the cultural constructs of traditional medicine and the extended family in Malawi and the welfare/health systems in Europe. Both are social, medical, political and economic. Seen in this light, European attempts at re-culturing Africans and post-colonial promises, 'renaissance' or otherwise, both without alternative and adequate social welfare and economic provisions are relevant. They promoted and will promote disharmony and disease. Banda (1946: 6) had, in earlier and perhaps more perceptive (in terms of appropriateness) times, noted:

... yet there is so much in the new culture that seems, not merely no better but actually less good than what they know of old...

sentiments currently echoed in the AIDS awareness song *Tikutha* (we perish) (D. Phiri, 1999).¹¹⁶ Both refer to the unsustainability of grafting western culture on a terrain that is neither economically compatible with it nor necessarily seeking such change. The colonial environment was not conducive to critical debates about the cultural dichotomies (Cf. Fanon, 1961).

Inter-cultural conflict produces persistent tension, subjugation or compromise in the form of hybridity or duality. Bhabha (1986 and 1994) argues that the site of compromise is the interface at which the cultures meet; the site of hybridity formation. An examination of the history of cultural diversity of Southern Africa confirms that cultural dualities predated colonialism. The proverb '*Mthengo mdalaka njoka*' (the forest defeated the snake), while acknowledging diversity warns those attempting to abandon their 'main' identity!

However, in the context of colonialism the colonial power was often perceived, and itself acted, as a subjugating force. This subjugating force has been viewed by some observers (Cf. Leys, 1975; Rodney, 1981; Ngugi, 1987, 1988) as producing an African elite crafted in the colonial mould.

¹¹⁶ See the full text of the song in Appendix 1.

These Africans, privileged by their wages into affording, albeit second-class, European lifestyles and services became divorced from the day to day realities of African peasantry life and lost some of their African cultural values and sensibilities. For the purposes of our study between culture, medicine and politics, Cabral (1980) comes close to tying up the connection between the colonial dualities and the economic 'productive forces'. He maintained:

[Culture] is the result, with more or less awakened consciousness, of economic and political activities, the more or less dynamic expression of the type of relations prevailing within that society, on the one hand between man [singly and collectively] and nature, on the other hand, among individuals, groups of individuals, social strata or social classes (1980: 141)'.

In this argument, colonialism, by through its coercive denial of African culture, using arguments of racial and cultural superiority, elicited the response of dualism among those of its subjugated people who could not be co-opted into the elite metropolitan life.

3.2 Aspects of colonial western medicine, education, gender and traditional culture in Malawi.

Butchart (1998: 2 - 6) has categorised the history of western medicine in Africa into:

- The history of western medicine in Africa 'as achievement [in establishing itself in a barren and hostile environment]'.
- The history of western medicine as a 'functional response to disease and epidemics'.
- The history of western medicine as repression.

The history of medicine in Malawi certainly has many features of this categorisation as this study and other observers' accounts demonstrate.¹¹⁷

¹¹⁷ Cf. King and King (1992), for example. Their account, a sympathetic account of the establishment and achievements of colonial and missionary medical efforts, perhaps by default and through highlighting the deficiencies, clearly shows the rural neglect. Baker's (1975) narrative and analysis demonstrates the way health resources were skewed towards European services. A number of

We have already noted African resistance to western culture and (rationed) medicine. Western medical repression is revealed by 'the concerns of the state and the ruling class in society', both with their own safety and with the reproduction of the labour force in the colonial (Kandawire, 1979) and, as we see later, the postcolonial eras (Lwanda, 1996: 19 - 37).

The Nyasaland Merchant's Association even tried, for example, in 1927, to restrict the supply of medicines to estate workers (Central African Archives (CAA) SI/1728/27). Until the early 1920s, the medical service was designed primarily to care for government officials (Baker, 1975: 301) and Europeans.¹¹⁸ Even after 1945, available resources were not applied universally, despite African protests and

... the influence of the War was not sufficient [to induce] a shift towards social service[s for Africans and away] from 'law and order' ... (Baker, 1975, 301)

most Africans continued to rely on traditional medicine (Ndibwani, et al., 1998).

A number of factors were responsible for this inequitable application of resources. First, much of its qualified medical staff was devoted to the 'care of the small and scattered European population' (Baker, 1975, 301), a self-preservation imperative partly arising from the mistake of settling in the 'malarious' territory (White, 1989; A. Ross, 1996). Second, racism, contributed to 'European only' hospitals, which survived until 1976 (Mkandawire, 1998: 114 - 115). Third, preventive medicine was ignored (Baker, 1975: 301). And the colonial preventive medicine on show either confirmed features of African causality in their hut destruction (smallpox) and isolation (leprosy) or revealed the coercive nature of colonialism by using 'smallpox police'. Fourth, the rurality kept many rural villagers unable to access western medical services and secure in their faith in traditional medicine. Fifth, primary education, in its Malawi setting, was, and as is shown later, continues to be dominated by traditional village culture. As

informants suggested that some mission hospitals like Likwenu (Malosa) were more egalitarian.

¹¹⁸ Cf. Mburu (1992: 410) who makes the same point for Kenya.

King (1988: 481) noted:

the ordinary primary school in Africa is still situated between two worlds [and] belongs to the village economy, [and] it is very close to the primary socialisation that has taken place in the home and in the rural community. Children take with them to and from school the home values they have already absorbed about health and nutrition ... In this sense, the rural primary school ... is part of the informal economy in which most Africans live, learn and work.

The introduction of universal primary education, in 1994, in the context of inadequate resources (World Bank, 1995: 10 – 17), has compounded this dynamic, making primary schools more ‘dependent’ on village resources and *culture*. Sixth, the racism and the favouring of elite ‘elite’ African workers encouraged the *mankhwala achizungu/achiboyi* (European medicine/boys (servants) medicine) duality. Yet despite its universal unavailability western medical agents and the state continued to attempt to abolish aspects of traditional medicine.

Gender

The post-colonial HIV/AIDS debates, which pathologised females, had colonial precedents.¹¹⁹ For example, sexually transmitted diseases (STDs) were noted, ‘among both Europeans and Africans’, to be a ‘problem’ from 1896. Kerr Cross (King and King, 1992: 125) noted:

Some 200 women were married ... to men of various tribes who had assisted in both the Expeditions (slave wars). I am sorry to report that this has been the means of spreading all forms of [STDs]’.

The arena of STDs generated the multi-faceted conflict involving gender (male chauvinism), tradition, Christianity and European concepts of African sexuality which was to produce a long running debate, dominated by views, then current in Europe, about Africans supposed ‘primitive, uncontrolled and excessive sexuality’ (Vaughan, 1991: 19 - 23 and 129 - 154) variously blamed on African ‘primitive customs and

¹¹⁹ President Muluzi ordered the arrest of prostitutes, and their ‘male counterparts’ in July 2000 because ‘they spread HIV/AIDS’ (*Daily Times* 28/7/00). Musicians in the early phase of the epidemic (1985 – 1992) pathologised and blamed the (usually female) sufferer, as Masaka Band did with their mid eighties hit *Watenga AIDS iwe* (you have contracted AIDS).

sexuality' or the ravages of colonialisation and industrialisation on Africans. However, both African traditionalists and colonialists saw African female sexuality as one of the main problems. Then, as now, traditionalists saw the loss of traditional control on women as contributing to their increased sexuality. During World War II the colonial authorities, aware of the recreational needs of their soldiers, treated African cases of STDs vigorously and with sympathy but blamed 'prostitutes' for the diseases. Females were coercively examined and treated.

Yet little in the role of ordinary rural women had, or has changed (I. Phiri, 1997) since Rangeley's statement (2000: 33):

A woman has a very servile position. She must kneel when she talks to a man... She must look the other way when men pass... She must work while her husband goes visiting and drinking. Yet, when women come into their own as at their female initiation ceremonies, no man dare interfere with them. No one could doubt the power of the woman if he witnessed the way they dominate the village, say at a Yao *unyago*. The fact is that women accept certain duties as traditional and they will be the first to object if those obligations and duties are interfered with, even if they are servile.¹²⁰

Traditional birth attendants, initiation rite organisers and other key females resiliently guard traditional practices during periods of rapid change (cf. Kamwendo and Kamowa, 1999: 165 -175). I argue that these traditions are guarded assiduously by women as (i) gender power roles and (ii) defensive mechanisms against forces of change and male gender. This dynamic affecting women continues, firmly rooted in localities.¹²¹ It partly explains the persistence of some traditions, for example initiation rites, which, while empowering specific women, are hazardous to women in general.¹²²

Interestingly while some women clung to their marginalized, but powerful in their context, role some men sought to overcome the consequences of breaking the sexual taboos laws like *mdulo* and *tsempho*. For example, with reference to sexually

¹²⁰ Rangeley's paper was first published in the *Society of Malawi Journal* of 1943. An identical reprint of 2000 has been used here.

¹²¹ Cf. Timpunza Mvula who examined the role of women's oral poetry as a social strategy in reinforcing beliefs and attitudes, which contribute to social and economic progress. In his thesis he states that 'there are multiple contexts in which only women perform songs' (1987: 184).

¹²² Cf. Munthali's findings of continuing *nsondo* practices among the Mangochi Yao; as well as Wamui's (2001) findings of the persistent strength of circumcision among the Kikuyu in Kenya.

transmitted diseases, Cullen's (1932: 230) observations included the following uses of traditional medicine:

To remove sterility or impotence... for venereal disease... to avoid harm after intercourse with a menstruating woman... for abortion... for safeguarding the community... for contraception... to conceal intimacy with a girl or with woman... to secure love... to conceal adultery... for one who has interfered with one's wife... for advanced syphilis... for securing knowledge of wife's unfaithfulness... that men may not die in consequence of adultery.

Of interest here, apart from the confirmation of treatment for sexually transmitted disease, is the fact that some of the uses of traditional medicine were to counteract the effects of transgressing taboos: e.g. 'to conceal intimacy with a [...] girl', to 'avoid harm after intercourse with a menstruating woman' or to 'conceal adultery'. As in all social systems and constructs therefore, there were resistances, covert and overt. The use of traditional medicine - itself part of the framework - permitted the social construct to remain despite transgressions of it, if the power brokers of the system, the traditional healers themselves, were involved in the propitiation of the transgressions. In Chapter Five we shall examine the prevailing cultural beliefs to see if these claims in colonial times by some traditional practitioners - to offer 'protection' against STDs, claims of crucial significance in the HIV/AIDS context persisted.

Despite the 'universalist and scientific attitude' to sexually transmitted diseases (STDs) during the war, 'European' concepts of 'African synonymity with disease and uncontrolled sexuality' survived, mutating into the 1980s HIV/AIDS debates (Caldwell, et al., 1989; Vaughan, 1991: 205 - 206).

Arguably, then, while appropriating some accessible, useful and colourful aspects of western medicine, for example the use of some western diagnostic rituals, addressing new threats and diseases and spawning peripheral hybridities in the process, traditional medicine, at its core, did not change fundamentally during the colonial period. And colonialism can be viewed as a brief, if significant, assault on some indigenous cultures (Falola, 1996).

The co-existence with and acceptance of western medicine should not be seen as its defeat of traditional medicine (cf. Peltzer, 1986). Vaccination campaigns, often seen as western medical successes, may, for example, succeed not because 'western medicine has conquered' but partly because they are seen as having 'replaced' previous variolation.

And, if yaws and leprosy treatments in the 1920s brought the 'injection' culture to Malawi, penicillin (for syphilis) consolidated it. Injections were later to contribute to HIV spread; in Malawi mostly via re-used poorly sterilised needles. Yet even the magic and potency of *jekisoni* (injection) could not abolish the duality (Feierman, et al., 1992: 268); Africans after all had their own potent scarification culture.

We would submit that from the colonial experience arose some hybridity and considerable duality, leaving significant parts of Maravi and Yao traditional medical culture unscathed (cf. Chanock, 1972: 429 - 441). This traditional medical culture is likely to have a significant input into the public medical sphere. Given the postcolonial issues of class, the urban versus rural dichotomy and 'neo-colonisation via globalisation', this continuing resistance is relevant to the HIV/AIDS discourse (Lwanda, 1999). This is particularly true where traditional medicine provides the bulk of services to the majority of the population.

3.3 Notes on the postcolonial politico-cultural contests

Because of the significant role that politics played in the epidemic an outline of some important political events that impacted on HIV/AIDS spread will be included here.

The postcolonial phase is dominated by the ambiguous figure of Dr Banda (Lwanda, 1993, Mphande, 1996).

By 1961, once the Christian Democratic Party (CDP) with its sizeable rural Catholic constituency was obliterated; Malawi was effectively a one party state (Short, 1974). The CDP was potentially an independent politico-religious power with rural

penetration, which - unlike the more co-optable Protestant urban elites¹²³ - was an obstacle to the cultural hegemony Banda desired. This intended cultural hegemony even received legitimation from UNESCO consultants (Cf. Phillips, 1982).¹²⁴

From the perspective of this work a number of events - the Cabinet Crisis, the muzzling of the religious organisations as an active civil society, the legitimation of a culture of political violence, the legitimation of the paramilitary organisation as a civil and military force (at the partial expense of the police), and the use by Banda of *ufiti* discourse in his handling of the Chilobwe murders – are relevant contextual processes to the subsequent balances of power between government and civil society. This balance of power, as we later show, required and continues to require the use and abuse of culture and resources by governance. Further, some of these processes were, in themselves (Cf. Chapter Four) promotive of HIV/AIDS directly or indirectly.

3.3.1 The cabinet crisis

The Cabinet Crisis has been given a pivotal role in the post independence history of Malawi (Mapanje 1981: 11; Short 1974; Rotberg 1966, Mhone 1992). The Cabinet Crisis was an important crisis point with a cathartic effect that enabled Banda to quickly consolidate his already powerful political hand by defeating his younger and less politically experienced colleagues. Banda, who had returned to lead the nationalist fight in 1958, was effectively already Party President for life by the time of the Cabinet Crisis (CC). As such the CC can be seen as one of a series of flash points in Banda's rise to absolute power. Usually seen in terms a power play between Banda and his younger more 'radical and modern' ministers there was, nevertheless, a substantial cultural element and effect to the CC. One of the disagreements concerned the issue of Banda's desire to revive the '*Chewa-ised*' (Lwanda, 1993: 9) Maravi empire (including

¹²³ The Presbyterians and Anglicans had more educated elite than the Catholics, ready to succeed departing Europeans, at the time of independence. This was due to the fact that there were more protestant secondary schools like Blantyre, Dedza, Malosa and Mzuzu secondary schools (Cf. Banda, 1982). At the time of independence, therefore, the Catholic Church had less co-optable elites. Ross, A. C. (1996) confirms this point. For a detailed account of Church/State relations between 1961 and 1999, please see Schoffeleers (1999).

¹²⁴ Phillips, for example, saw the Malawi Young Pioneers, the University of Malawi and the Malawi Congress Party as agents of cultural development.

parts of Mozambique, Zambia and Tanzania) (Hedges, 1989: 620 - 622).¹²⁵ This wish was given credence by his subsequent border disputes with Tanzania and Zambia. One of the crucial factors leading up to the CC was the variance of views over economics and the politico-cultural outlook between Banda and his ministers. Most, but not all, of the latter, like their departed colleague, Dunduzu (1965: 1 – 18) favoured a mixed economy that combined aspects of both socialism and capitalism – what he called ‘communalism’, a concept thought to be more resonant with social aspects of traditional African life. Banda favoured a capitalist approach; but this was capitalism with strong vertical patronage networks, ultimately centred on himself. To succeed, this form of patronage required the recruiting of Chewa traditional hierarchical patterns in its construction.

Further, Chisiza (1961: 1 - 21) had written about the dilemma both he and Banda must have been, on the eve of acquiring power, acutely aware of

One of the trickiest problems for new countries is that of picking out customs and traditions, which must be discarded, and selecting those foreign cultural patterns that must be adopted...

And:

It should be their [African leaders] duty to look at the recommendations [for change] from the angle of their people and to select those (1) which show signs of being the most practical; (2) which will not take too long to implement; (3) which have less unfavourable effects on the psychological welfare of the people, and (4) which will not raise new problems...

And, finally and more relevant to this discourse:

To keep social conformity at its minimum, political leaders must refrain from playing the double role of political as well as social leaders. Social leadership should be the responsibility of different people who should be given due recognition and encouragement by the political leaders. But

¹²⁵ Banda stated that his policies were partly motivated by the need for rapprochement with the Portuguese, who controlled the land-locked Malawi's routes to the sea. Banda hoped to obtain a slice of Mozambique north of the Rovuma River in exchange either for the Southern tip of Malawi or for providing a buffer between independent Tanzania and the remaining white states of Mozambique, South Africa and Rhodesia (Rotberg, 1966: 317; Hedges, 1989: 620 - 622). The term *Chewaisation* refers to Banda's political empire project based on Chewa culture (Cf. Lwanda, 1993: 16 – 19; and Chirwa (2001: 10 - 17). An insight into Banda's politico-cultural formative years is contained in his views in *Our African Way of Life* (Young and Banda, 1946).

the base of social leadership should be so broadened as to accommodate a variety of tastes and ideas thereby preventing the popularisation of a few pet ideas originated by a handful of people. Lastly it should be made clear to social leaders that their job is not to throw overboard everything African nor merely to process foreign ways but to uphold African ways of life where necessary, to adopt foreign ways where possible and to strike practical compromises where need be (Chisiza 1961: 17-21).

A communalist approach would have, in theory, led to a broader social leadership, and perhaps, for our study, more willingness to accept differences. The capitalist approach, which Banda eventually favoured, with its in-built vertical hierarchies within a one party state promoted the imposition of a homogeneous syncretic cultural ethos based on capitalist *achikumbe* (master farmers), *achikulire* (patrimonial political leaders and elites), all dependent on hierarchical leadership dependent on the Malawi Congress Party. This produced a stultifying and inhibitive political and cultural discourse, symbolized by strict cultural controls via formal and informal agencies.¹²⁶

But by the time of the Cabinet Crisis, Dr Banda made it clear that:

Either I am a Prime Minister who governs this country, guides the affairs of this country or I am nothing. I have not the temperament of a puppet, a figurehead, a cipher. I just haven't that temperament at all. There are people who have that kind of temperament but I am not one of them... I wasn't at the University of Chicago for nothing. Remember it was only after I had my degree in honorary arts, history, politics and psychology and all that, that I entered medicine. And when I entered medicine, [to what I'd studied] I added psychiatry... (Banda's speeches, 1964 – 1971).

This authoritarian streak has been ascribed by some observers (Cf. McCracken, 1998b: 231 - 250) to a pre-existing tendency in the Malawi Congress Party and its predecessor the Nyasaland African Congress (NAC) and can be seen as a corruption of the *ngwazi* (the hero who kills a lion) cult. It can also be traced to dynamics within Banda's own early experiences. Chipembere (2002: 335 – 344) has given an account that suggests

¹²⁶ Malawi had, and still has, a Department of Culture within the Ministry of Education.

that the younger NAC were afraid of him as soon as he landed at Chileka.¹²⁷

A more overtly medical cause for the Cabinet crisis was the proposed three-penny charge on attendance at government hospitals, which Banda approved, and his younger ministers resented. This was an income generation measure designed to improve services for Africans by replacing funds previously provided by the defunct Federal Government. This, significantly, was to be achieved without diluting the services for whites. However the younger ministers saw this as punishing the poor. Culturally, however Banda was on firmer grounds since people traditionally paid in cash or kind for medical services obtained from traditional practitioners. And mission hospitals usually charged for their treatment. And yet for urban African elites this was a new thing. Interestingly, Banda had already covered his corner with his oft-repeated exhortation to

[Independence means] hard work... My policy has always been this: that whatever else my people, as I always refer to them, might not have, they must have food, decent clothes and houses that do not leak when it rains (MBC broadcast 1989, transcript in my archives).

Another disagreement arose over foreign policy; Banda was outwardly opposed to communist regimes, and resented his younger ministers being

dangl[ed] bribes [from the Chinese, allegedly] before my face and eyes, is not, Mr. Speaker, easily understandable by an Elder of the Church of Scotland... (Banda quoted in Short, 1974).

Ross, A. C. (1969: 55 – 63) attempted to sketch a political role for the witch finder and *ufiti* discourse in the Cabinet Crisis. His brief account is unhelpful in that it deals more

¹²⁷ Chipembere's autobiography (2002), written from memory while in exile, gives a valuable insight into the political background of the 1950s and 1960s. It is rich in personalities and politics but lacks the theoretical and academic intensity of Chisiza's writing. Of more relevance to this work is his disclosure that, despite his Anglican education at Likoma and his father being priest, he experienced a period of *ufiti* fright (2002: 90 – 91) while at Blantyre Secondary School (1947 – 1949) and that his mother 'always lived in fear of it').

with the colonial phase than the postcolony and identifies *ufiti* discourse only with the uneducated *anthu wamba*.

3.3.2 The Religious complicity

Banda's initial rejection of Communism became a rejection of sources of funds unacceptable to 'a Christian Church Elder' like him. It was also one of the first overt codes by Banda appealing to both African gerontocracy (wise Elder) and Western Christian (Church elder) opinion and support. This recruitment of international Christian support and legitimacy had political and cultural effects. The younger ministers were stigmatised as Communist rebels even though there is evidence to suggest that both Henry Chipembere (despite his being a firebrand) and Orton Chirwa, the two more senior of the young ministers, were regarded as, at worst moderates and at best, right wing and pro-Western politicians; the same could have been said for Willie Chokani, another Church Elder.¹²⁸

Once this religious legitimacy had been established (Ross, K, 1998) the use of the Church was encouraged to identify with the 'Unity, Loyalty, Obedience and Discipline' ethos of the Party. This manipulation of the Churches affected all religious groups. During the aftermath of the Cabinet Crisis there was a growth in both Christian and Muslim culture in Malawi. Longman (1998) noted the potential of religious organizations to act as active civil society agencies, and also as complicit bodies:

Christian churches play sharply contradictory roles in African societies, both helping the ruling classes maintain their domination of the masses and helping the masses resist domination. [Work in Rwanda, Burundi and Congo shows] that various social groups vie to use the churches to support their political programs. In Rwanda, for example, both supporters and victims of genocide received assistance from the

¹²⁸ Indeed Chipembere, according to Ross, was taken out of Malawi by the CIA (Personal communication, Ross, AC, 23/5 02).

churches. Churches have no predetermined relationship to structures of power, but represent important sites of contestation, a fact that challenges the view that civil society, in which churches are a vital segment, necessarily serves the interests of society as a whole (Longman 1998: 55).

In Malawi, the post independence persecution of the Jehovah's Witnesses, whose religious culture predetermined their contest with the state, was a case in point; it consolidated a culture of intolerance and politico-religious violence. This was a battle against the state that the other religious organizations did not relish; their silence legitimized Banda's hegemony from the religious perspective. The postcolonial Malawi religious revival was thus a religiosity without social justice.¹²⁹

3.3.3 Politics and the culture of violence

It also was during the cabinet crisis and its aftermath that the most far-reaching intrusion of the state machinery into the realm of culture occurred. The machinery of state security, police, army and the paramilitary forces were mobilised to fight the ensuing Chipembere (in 1965) and Chisiza (in 1967) insurgencies. During this period the general population was mobilised to an extent that achieved several effects. First. Local communities associated with dissident ministers like Malindi in Mangochi were multi-targeted: the security apparatus flushed out armed rebels; many leaders - both with conventional and traditional education - were detained in an attempt to remove dissident opinions and thought; cultural societies like *beni* groups and initiation groups were constrained in their function; for example there were problems with simple functions like herb gathering and the setting up of initiation camps. Second. A national network of informers was established. Visitors to any village had to report not only to

¹²⁹ This religiosity without social justice context threatens to return in the Twenty First Century as the Christian Churches and Islam lose the power they had re-appropriated (Malawi Catholic Bishops, 1992; Ross, K, 1993: 1 – 6 and 12 – 14; Ross, K. (Ed) 1996: 15 – 62) during the 1991 – 1994 transition from one party to multi-party rule.

the local village headman or chief, but also to the local party chairman. This period of intensive security (a state of emergency based on old colonial laws) enabled the party chairmen to gradually encroach into the powers held by village headmen in matters of land and cultural activities involving public gatherings. As Kerr observed, in the context of community theatre activities in villages:

The Malawi Congress Party permeates every level of Malawian Society, with a tightly controlled network from the National to regional to District to area to Village level. Mwima has an Area party Committee divided into ten branch committees one for each of the main villages. Parallel to this is the traditional structure of chiefs and village headmen... The intense permeation of Malawi's ruling ideology and one-party machinery, right down to the grass-roots level, makes it difficult for any non-violent, but combative countervailing movements to take root. At no time did the catalysts or the villagers seriously take issue with fundamental organs of state power, even when linkages between that power and the causes of local underdevelopment were exposed by the plays. Particularly when the villagers created their own plays, without assistance from the Theatre for Development team, the local Party political leaders were very careful to integrate the play into the routine of MCP political ritual (Kerr 1989).

Conclusion

This culture of deterrent physical violence, implied violence and a pervasive informer network resembled and exceeded the colonial regimes taboos. It also had, despite its artificiality, elements of punitive pre-colonial taboos. And yet, as Kumpolota and others showed, the traditional healers continued their localized practices. This continuity was achieved by hiding some aspects from the postcolonial gaze. A well-known manifestation of this was the practitioners' judicious use of the flywhisk Banda had appropriated for himself.¹³⁰ As in East Africa (Iliffe, 1999) medical doctors lost much of their traditional and professional authority to politicians directly and indirectly - by myriad rules and regulations that placed party dogma above the rule of law.

¹³⁰ See below for an account of this phenomenon.

3.3.4 The Malawi Young Pioneers and Youth Week¹³¹

Another direct and indirect result of the Cabinet crisis was the empowerment of the population, both indirectly in a Foucauldian manner to spy on each other, and directly by the creation of the paramilitary Malawi Young Pioneers, an organization designed to teach agricultural skills to school leavers as well as enforcing political stability. Banda spelt out his design at Chileka airport on 26th July 1964

Watch out, watch everything. You the common people are the real MCP. Watch everybody. Even Ministers, and I tell you even when they are present, right here. Watch them, everybody. Watch members of the Central Executive, watch members of the National Assembly, watch everybody, and if they do what you do not think is good for the MCP, whether they are Ministers or not, come and tell me... Women's' League, you are my spies. Tell me everything that you hear (Moxon, 1964; MBC, transcripts, 1964).

This empowerment of the population extended to giving villagers the right to be judges and juries as Banda made clear in a speech at Chileka on 13th September 1965:

Watch out for anyone, ... [The minute you see anyone who has run out of the country], the minute you see him anywhere, Youth Leaguers, Young Pioneers, Members of the MCP, arrest him right away. Do not go and report to the Police... Just arrest him, that's all. And if he resists, do something to him. These people are wild animals now. They must be destroyed. No beating about the bush... (MBC, transcripts; MOI, 966/65)

This empowerment of the populace was eagerly accepted by some of those with the means to turn this power into economic activity: the petty traders, small shopkeepers, party officials, and others who used this power to overcome opponents and potential

¹³¹ 'Youth Week' was a weeklong festival to celebrate the achievements of the post-independence Malawian youth in the fields of agriculture, education, culture and community development, under the 'wise leadership of the Ngwazi Dr Kamuzu Banda' (Malawi News Agency, 1977; Devgon, 1972: 32 – 5; Mphande, 1972). It utilised virtually all the available educational, cultural and broadcasting resources.

opposition using the *kuthetsana* (finishing each other by reporting them to Banda's spies) tactic. During the 1967 Chisiza incursion the population was again mobilised using a saturation propaganda campaign using the radio, the printed media and the Malawi Young Pioneers and the Party. Banda said of the rebels:

To prove that [people are solidly behind Kamuzu] the gangster captured today was [captured] by the villagers themselves. If you see any strange face in your village, in your garden ... report them to your party leader immediately ... Better still ... arrest them yourself, and if they resist, kill them. You have hoes, axes, ... bows and arrows. This is war and not cricket. In war we must not play... (Ministry of Information, 1967)

This carte blanche sanction to report strangers, arrest trouble makers, report Jehovah's Witnesses who refused to buy party cards and respect the flag, and report those expressing dissident thoughts, was almost enough, even without the presence of the police to give party chairmen a strong hold on the 'obedience, law and order' situation in the villages. It was also enough to emasculate the village headmen and chiefs, particularly as the party chairmen up and down the hierarchical scale began building their own patronage empires. These patronage mini-empires were based on economic, political and cultural considerations, as well as land. The ascendancy of the MCP hegemony gave the Party chairmen in the villages power to interfere in the local land disputes and distribution. The rise of the Malawi Young Pioneers, therefore, interfered with the patterns and cultural constructs of order maintenance. Contrary to most studies of the MYP, far from promoting hierarchical considerations of obedience to elders, the Young Pioneers were put in charge of and gave instructions (both originating from the centre and from themselves) to village chiefs and elders. The latter resisted, a resistance manifest in cultural and other forms.¹³²

The formal establishment of the Malawi Young Pioneers was accelerated after the

¹³² A discourse of resistance to the MYP arose. They were, for example, called *chiswe* (termites) because of their 'cowardice as individuals' but ability to effect massive destruction as a group.

Cabinet Crisis; in 1965 legislation made the MYP 'an integral part of the security forces (MYP Bill 1965)'. MYPs were settled in various agricultural schemes in fertile valleys throughout the country. From these bases agriculturally trained Young Pioneers taught rural people 'productive and healthy' agriculture (MNA, MBC transcripts 9/4/65). One of the first bases to be established was at Katuli, near Malindi, in Mangochi district where, Banda explained

They will not only be taught agriculture but also how to shoot machine guns and to hunt the whole area for anything hiding in the bush (MBC 9/4/65).

MYP bases were thus chosen for both agricultural and political strategic reasons.¹³³

The complicated link between labour, rural poverty and politics was revealed when the Finance Minister, John Tembo, in 1965, revealed some of the initial sources of funding for the MYP. The revelation sheds light on the peasantry's subsequent perspectives of the Chilobwe episode in 1969.

Presenting the estimate, the Minister of Finance, Mr. Tembo, said that, of the estimated expenditure £20,000 to £30,000 would come from the sale of the passports to Malawian nationals working in South Africa... (MBC, 9/4/65)

Eventually, MYP bases were established in every district and MYP cadres and graduates were settled in most villages. MYP activities came to include carpentry, agriculture, teaching leadership and self sufficiency skills, teaching political education, commercial activity including Spearhead Enterprises, cattle ranching, dairy farming, estate farming, transport as well as the paramilitary activities (see Crosby, 1980: 116 - 117). These establishments and activities were often at the expense of villagers who

¹³³ Mangochi district had been the base of Henry Chipembere, when he began his armed insurrection after leaving the cabinet.

had to be 'resettled'. The MYP also became culture brokers for the youth, with activities including traditional dances and popular music. Their Spearhead Band, for example, specialised in reggae music, but not of the 'subversive' Bob Marley type. Those who see the MYP as essentially a positive disciplinary force miss the point that their existence had to be constantly justified by the presence of negative anti-state forces. These anti-state forces inevitably were 'dissidents', 'rebels' and 'troublemakers', real and imagined; but cultural dissonance, whether miniskirts, bell-bottomed trousers, long hair and unacceptable literature, were also their province. Unfortunately, the subject of health education was not advocated, the MYP regime being associated with a regime of 'survival of the fittest'.

Many aspects of traditional culture - dances, arts and crafts and drama - were appropriated for purposes of the Party or praise to Banda and the Party. This appropriation placed a large burden on the rural population in terms of time, materials and money (Lwanda 1996).¹³⁴ The overbearing presence of the Party and its agents also cut across the modes of inter-generational training in things like dances, traditional medicine and other publicly performed cultural activities; these usually needed Party approval. The cultural effect on elites was more obvious when measured in terms of restriction of personal, political and academic freedom, aspects of the dress code and aspects of the Censorship code which deprived them of substantial segments of indigenous and world literature and performing arts.¹³⁵ A less obvious and quantifiable culture was that of the need to survive; this, given the poverty of Malawi, survives in

¹³⁴ This diversion of energy, resources and intellectual capacity away from health, social security and other development sectors towards the praise and sustenance of the leadership is one of the unexplored anti-developmental discourses in postcolonial Africa. It is suggested that African cabinets should, without any loss of sovereignty by these states, effectively be on United Nations 'international civil service' salaries. As 'civil servants' they would be unable to engage in the diversion of resources or tinker with constitutions and would concentrate on efficient and more development oriented running of their countries. The resources required for such a scheme would far less than is wasted at present. Current NEPAD (New Partnership for African Development) proposals are less radical and enforceable than this (Cf. Nkuhlu, 2002; Olukoshi, 2002; Ellerman, 2002; and Hansen, 2002).

¹³⁵ See the Malawi Censorship Board's Classification Guidelines (n.d.: 1 – 7).

the 'personal poverty alleviation' of the Muluzi era.¹³⁶

Although there was a rural continuity, healers were affected by the attempted cultural homogenisation and ambiguity. Aspects of traditional medicine became the subject of ambiguity with practitioners unsure of the official attitudes. Banda's duality meant of course that no official attitude or guidance was forthcoming. While it was implicitly encouraging aspects of *nyau*, the government was discouraging *jando* and advising Yao children to 'attend school'. And while elites were not beyond covertly using traditional healers to achieve states of fortification, *kukhwima*, publicly they seemed ashamed of using traditional medicine.

The ascendancy of the MYP during the 1960s and 70s has to be contrasted with the agent of modernity, the educational system. The MYP system expanded to include bases in every major area. More money was spent on this expansion than on that of the educational system. In government documents MYP expenditure was disguised as part of the General Administration vote (DEVPOL, 1987: pp 142 and 182). The expansion of the educational infrastructure enabled less than 50% of school age children age to attend primary school by 1970. Both primary and secondary school syllabi were closely controlled and restricted in educational, historical and cultural aspects. Tertiary centres of education, like the Soche Teacher Training College and the University, founded in 1964, experienced censorship and political direction in the syllabus (Short 1974; Williams 1978; Forster 1994; Kalinga 1998).

Through its intellectually restrictive treatment of intellectuals, particularly northern university lecturers, the use of MYP cadres to 'control' secondary school and university

¹³⁶ 'Poverty alleviation' (PA) was Muluzi's United Democratic Front operative development programme. In a critique of the Poverty Alleviation Programme, Chinsinga (2000: 15 - 16) concluded that it was associated with a lack of political will for the required agrarian reforms, that it was politically driven for rent purposes and that it was largely externally driven.

students and Banda's apparent mistrust of graduates after the Cabinet Crisis, the MCP administration exacerbated an anti-intellectual tendency in Malawi (Africa Watch, 1990; Vail and White, 1991; Lwanda 1993, 1996).¹³⁷ Banda had made it clear early on that

The university should be a part of the life of the people... We have to teach [outside things to give students a world context and appreciate how others live] but we have to make the university meet the needs of this country after all this is Malawi, not Britain, not Germany, not France... Our university has to be part and parcel of the people (Banda 1965, transcript in personal archive)

The strict Dress Code - which banned miniskirts, bell-bottomed trousers and other 'decadent Western influences likely to corrupt the youth' has been seen in terms of an attempt to impose a national unity of conformity, to protect the youth from developing independent tendencies and also to appeal to the rural elders who would agree with the ban because of its apparent convergence with traditional values (e.g. Forster 1994). Banda was also anxious to reduce the gap between the elites in secondary and tertiary education or in urban employment and his MYP cadres and Youth leaguers in the villages. One of the distinguishing features between urban and rural youth is in the manner and mode of dress. Phiri, K. (1998) makes the point that the aesthetics of Malawi Congress Party matrons were scandalised by the Western dress sense of the young and their concept of a national dress - essentially, as White (Personal communication, 1993) suggested, an adaptation of Victorian working women's attire. But there was an ambiguity and duplicity here; the same Party matrons wore Western attire when on private visits abroad and in the privacy of their homes. The need to promote the local textile industry then in competition with *Zambia* (Zambian) and *Kitenge* (East African) goods is likely to have played a part.

¹³⁷ See also Joffe (1973: 571) 'It is this isolation of the educated elite from politics under Banda's regime that will determine the future course of Malawian politics after Banda's departure.'

The Censorship Act of 1968 with its draconian restriction of intellectual, cultural (films, books, videos, journals) and curricular fields was both a straightforward political tool as well as a reflection of Banda's Puritanical traits and vision of Malawian culture. This vision was most effectively crystallised in the declaration of Chewa as the national language in 1968, leading to the cessation of broadcasts on the Malawi Broadcasting Corporation (MBC) in other vernacular languages. Although some observers have placed a great deal of emphasis on seeing this as Banda's 'imagined nation' (Cf. Forster 1994) the imposition of Chewa was also to a significant extent Banda's move to consolidate his hold on the Chewa.¹³⁸ It must not be forgotten that in 1967 - 68 there had been discontent in the Central region. R. B. Chidzanja, the Central Region Minister was beaten at a funeral; and Banda himself had admitted, at the MCP convention in Mzuzu in 1970

The second thing that pleased me about this conference is that unlike the 1968 conference in Lilongwe, or the one in 1967, right here in Mzuzu in this hall ... there was absolutely no friction, no sign of friction among these people here (executive and senior leaders). [And as a result] there was no friction among the delegates.¹³⁹

At the Mzuzu dissenting chiefs were beaten by members of the MYP, then commanded by Gwanda Chakuamba, over the issue of Manoah Chirwa.

Conclusion

Banda's cultural and political strictures resulted in a national culture of public probity and Puritanism, but private rebellion in intellectual, sexual and cultural mores. Between 1965 and 1991 Banda's state can also be shown to have exploited the ordinary workers and peasants through forced donations, passport taxes and other indirect taxes at a time

¹³⁸ In 1968, four years after independence, Chinyanja – later renamed Chichewa, after the 'pure form of the language (as Dr Banda held it) spoken in the Central region' - was made the national language Cf. Kamwendo et al, 1999).

¹³⁹ The chiefs did not know that Banda opposed the exiled Manoah Chirwa's return to Malawi.

when Banda was claiming to have improved his people's standards of living. The tension between the state and its people resembled, and often exceeded, that in the colonial period. This culture was to contribute to the observed gap between national aspiration and observed behaviour in the HIV/AIDS discourse.

3.3.5 The Chilobwe murders

The background to the 'Chilobwe Murders' lies in the covert opposition to the Banda regime among the low paid workers and some of their elite leaders, in the urban areas of Zomba, Blantyre, and Lilongwe, as well as the tea growing areas of Mulanje and Thyolo.¹⁴⁰ These workers shared the grievances of Malawi migrant workers. After Malawi had established diplomatic relations with South Africa, in 1967, the expectations had been that conditions and wages for those trekking to work on the mines would improve, as would the economic climate and employment opportunities in Malawi. In the event there was actually a leveling off in the salaries of the low paid; this was at a time when the small middle-class was benefiting from foreign aid. Particularly hard hit were the shantytown dwellers, tea and other estate workers who did not have the rural areas subsistence base to fall back on. And the labourers who ventured to South Africa continued to suffer the same restrictive and humiliating conditions. Yet they were, and many realized this, a crucial element in Malawi's foreign earnings. These multi-faceted grievances coincided with the political ascendancy of Gomile Kumtumanji, a Yao, to the important Southern Regional Ministry.¹⁴¹

However, a few months before the beginning of the Chilobwe murders, Kumtumanji

¹⁴⁰ I lived in Mulanje during my school holidays from 1964 to 1967 and then in rented accommodation in Chilobwe from 1967 – 68. The tea growing areas of Mulanje and Thyolo and the urban slums of Blantyre hosted a repressed, poor and discontented peasantry (Cf. McCracken, 1998a, White, 1989, Mhone, 1992).

¹⁴¹ The Southern region was, and still is the most populous of the three regions. Kumtumanji had supported Banda during the cabinet crisis. The Yao (Cf. Chapter Two) are keen traders, migrant workers and have sophisticated networks.

had mysteriously resigned from government. In Banda's time a resignation was tantamount to a sack (Cf. Short, 1974; Williams; 1978; Lwanda, 1996).¹⁴² From 1968, for a period of about two years mysterious killings occurred in the densely populated low amenity suburb of Chilobwe, adjacent to Zingwanga. The killings were of a ritual nature with victims randomly selected, their heads severed with sharp instruments, and the killings generally occurring around the seventh of the month. Despite saturating the area with informers, Malawi Young Pioneers, soldiers and police the killings continued (Legum & Drysdale 1970: B150-152).

As if to explain their failure to stop the killings, Banda described the mysterious killers in a speech on 30 September 1969 as *afiti* (witches) (Legum & Drysdale 1970). This only compounded the widespread rumours which were ascribing the killings to the need for the Malawi government to pay South Africa, for the loan granted to build the new capital at Lilongwe, with Malawian blood; hence the ritual killings with *kuchotsa magari* (blood being drained from the victim). The newly started Malawi Blood Transfusion Service had been appealing for blood earlier in the year, and these rumours could be ascribed to this coincidence. The then Minister of Agriculture, Gwanda Chakuamba protested:

We do not have to pay for our loans with blood or by selling our people. We have the richest soil in this part of Africa. We simply repay our loans by producing the high-quality crops (Legum & Drysdale 1970: B152).

This only succeeded in confirming in the minds of the peasantry, who were aware of the travails of the *theba* (hard work, approximating slavery) in migrant work, and who were aware, if only by exaggerated rumour of the multiple ritual deaths occurring in

¹⁴² My own investigations involved several interconnected issues over which Banda and Kumtumaji are supposed to have differed: the freedom of Muslims to practice and travel to Mecca, the related Jehovah's Witnesses persecution, Banda's paranoia about powerful lieutenants (Kumtumaji was number three in the hierarchy at this time, after John Msonthi) – and Kumtumaji was politically ambitious and, as later achieved by Bakili Muluzi, exploited and galvanised Yao networks.

their midst. It took the arrest and trial of Kuntumanji to partly lay the ghost of Chilobwe. But, significantly on this and subsequent occasions, Banda had been hoist by his own cultural petard. Having raised the *ufiti* question, his arrest and disposal of Kuntumanji was bound to be seen in terms of a tussle between two *achikulire okhwima* (fortified big men).

Culture was Banda's 'legitimising tool' (Lwanda, 1993, Forster, 1994). His 'creation myths' included the attribution of his plans and achievements to his 'Gwelo [colonial prison] dreams' in line with African traditional religion and medicine (Chimombo, 1989). Coincidentally *Gwelo* in Chewa means 'source!' To survive politically, in this 'taboo laden' regime many 'otherwise Christian or Muslim' politicians 'justifiably' resorted to fortification, *kukhwima*. Banda, the *bwana mkubwa* (governor-general),¹⁴³ allegedly 'built more prisons than hospitals' (Mapanje, 1993) and, like the colonialists, did not encourage African western trained doctors. By 1992, only 25 out of 175 sent for medical training had returned (King and King, 1992). As in colonial times, clinical officers delivered the bulk of western medical services.¹⁴⁴ Banda's cultural ambiguity contributed to the resurgence of postcolonial traditional medicine, via his ubiquitous flywhisk, a gift from 'the traditionalist' Jomo Kenyatta (Kenyatta, 1946). A flywhisk (switch), a sign of nobility, medical status or fly swatting tool is also a potent *kukhwima* symbol. The Yao used switches in initiation, *ngondo* (war), raiding (*ciswamba*) and as defensive symbols. Preparing tail-switches may involve rituals, herbs, *ufiti* (witchcraft), animal or human parts, and 'religion'. Given that, '... merely to carry this tail is usually sufficient to ensure protection from wizardry' (Sanderson, 1955), and the absolutist 'zonse zimene za Kamuzu' (everything belongs to Banda), the flywhisk symbolised Banda's potent *kukhwima*. No traditional practitioner then dared to use flywhisks in

¹⁴³ African chiefs called Banda *bwana mkubwa* (big chief or governor general).

¹⁴⁴ Clinical Officer: a non-graduate medical officer trained to diploma level, who provides clinical care to patients in Central and district hospitals. Between 1980 and 1997, 362 clinical officers were trained (Personal communication, Masache, 10th August 20001).

public. This unambiguous nod to traditional culture in the postcolony marginalised African medical doctors and privileged a 'localised' traditional medicine, which avoided direct engagement and or confrontation with his regime, perpetuating the cultural duality and neglect of rural health needs. Concepts of *mankhwala achizungu/achiboyi* (European/servant medicine) persisted. Later, only *achikulire* (the elites) could afford expensive anti-HIV/AIDS drugs.

Interestingly, Kamuzu Academy, a major element of Banda's educational legacy, where students were '... crammed with Latin, Ancient Greek [... and] you will not spot a single black teacher' (McGreal, 1992), provides many College of Medicine (COM) students begging the question as to how the COM graduates will handle the cultural dichotomy. That some drank *mchape* (the [body] cleanser) in 1995 (written unattributable communication, 1995) indicates desperation or an established duality.¹⁴⁵

Significantly, the 'programmatic philosophy' of the new medical school (Ministry of Health, 1991a)) was in 1988, seen as emphasising community health and practice (page 13), but 'traditional healers have no formal ties to the MOH system' (page 4). On its inception in 1992, the College of Medicine put Community Health as the 'cornerstone of its curriculum' (Muula and Broadhead, 2001: 156). However, the epistemological and integrative debate between community medicine as perceived by the College and the reality of community medicine in the rural areas, has yet to begin in earnest. In the ambiguous cultural climate sketched above, the new disease HIV/AIDS arrived and found the epidemic control measures, neither traditional nor biomedical, wanting. We also note that, particularly from having examined the Chilobwe incident, there were aspects of state use of *ufiti* discourse. Further, in 'puritanical' Malawi, discussions of sex were taboo, although sex, with discretion, was one of the few forms of politically

¹⁴⁵ Rangeley (2000: 74) asserts (of the 1930s and 1940s *mchape*) that: 'In fact, it was often the educated Africans who were among the first to drink *mchape*.'

safe entertainments in urban areas (Mapanje, 1981: 22).

3.4 Conclusion.

Any possible epistemological dialogue between traditional medicine and western medicine was thwarted by considerations of race, limited resources and economic considerations, religion, class and the failure of the colonial authorities to identify the reification of borders and reduction of available African land as a major cause of poverty. While wishing Africans could follow western concepts of health, colonial authorities did not provide resources for this. Africans continued to rely largely on traditional medicine. The impact of colonialism, it is argued, while disrupting the national or tribal/ethnic structures, and their associated medical frameworks, saw these frameworks retreat into village localities where, for a number of reasons, including poor resources, they were only minimally challenged. Given that education, particularly medical education, would have empowered Africans to clamour for more resources, Africans were restricted to junior and servile roles in the health service. From these roles it was impossible for them to conduct any meaningful dialogue with either western or traditional medicine. A secondary effect of this was that a tradition of using medical education as a means to self-improvement, rather than the acquisition of a critical tool, was established, exemplified by Kufa, Banda, and Malekebu. This tradition persists.

Further, neither colonialism nor the postcolonial hegemony, therefore, significantly altered the traditional medical beliefs and practices. Here, post-coloniality is viewed as an ambiguous re-inventive and re-assertive factor. And, it could be argued that, in its greater threat to, and greater penetration of the rural space, post-coloniality contributed to further efforts by localised culture brokers to guard their practices against the postcolonial hegemony.

At independence the African elites, given similar economic considerations as the colonial regime had, opted to continue the same model as under colonialism: limited western medicine, minimal western health education, the availability of western

services based on considerations of race and class (Cf. Ngugi, 1982). Understandably, and significantly for this study, a mentality of aspiration (to western services) versus the reality (of the significant unavailability of these services) was established particularly among those in school. As we will discuss later in Chapter Four, in line with Hall's theories (1996) the result of school education produces a 'translation' as a result of the mixing of traditional and global/western influences to produce cultural hybridities. For the purposes of our thesis, these hybridities, depending on their class and ability to access resources are able to move between the traditional and urban/western culture.

These issues of class were seen during the Cabinet Crisis, when a 'pragmatic', but essentially free market approach to health was adopted in Malawi. The unwritten rule was that most Africans would manage on minimal western services and traditional medicine. Banda continued the colonial rural medical neglect and promoted better (or private) medicine for elites (cf. Short, 1964). Second, his 'culture of dictatorship' drove discussions of contentious medical, cultural or political matters underground; perpetuating the 'political duality' of the colonial era and bringing corrupted 'village culture' and 'preventive taboos' to the national stage. In sum, taking the CC as a political and cultural turning point we note that the postcolonial governance led to:

- An attempted cultural and political hegemony, the empowerment of small trader elites to acquire land at expense of peasants.
- More land being removed from peasants.
- Stricter censorship for elites.
- Delayed epistemological dialogue between the traditional and western elements
- More cultural practices being driven underground, perpetuating the colonial pattern.

These factors contributed to the worsening of poverty through loss of land by the poor. They reduced epistemological debate by constraining debate and they strengthening localised traditions. And, in contradiction to Banda's perceived modernity, his regime was not averse to using *ufiti* discourse - as noted during the Chilobwe murders and in his own use of a medicine man's flywhisk to facilitate control, potent symbols in a

largely oral culture. Finally, it is contended that these localised traditional medical beliefs and practices, even as they themselves undergo evolution/reinvention continue to thrive and inform beliefs towards both traditional and western medicine. As we shall see in Chapters Four, Five and Six, they continue to inform attitudes and actions relevant to the HIV/AIDS debate.

CHAPTER FOUR

The history of HIV/AIDS in Malawi

Chapter methodology

This chapter, examining the history of HIV/AIDS in Malawi, utilises historical research methods using data obtained from literature review of archival and personally gathered data from personal research, oral interviews and news monitoring. It also benefited from my personal observation of the HIV/AIDS epidemic in Malawi from 1993 to the present.

The first task here was an extensive literature search of published and unpublished material and Internet sources. British library sources contained fragmentary information, dealing mostly with clinical material or the ‘African sexuality and denial’ debates.¹⁴⁶

In addition, during 1994 – 1995 and my field trips in 1999, 2000 and 2001, I added to my database with information from the libraries at: the Centre for Social Research (SCR), which has a range of clinical and social data relating to HIV/AIDS data; the Malawiana (Chancellor College); the Ministry of Health (MOH); the National Aids Control Programme (NACP); the College of Medicine (COM); and Kamuzu College of Nursing (KCN) libraries. The COM hosts the St Johns Hopkins research team in Malawi, the authors of many clinical papers on HIV/AIDS in Malawi (Appendix 2).

Oral interview material was contrasted with written material to give an added

¹⁴⁶ A number of western observers felt that there was a denial of the extent of the HIV epidemic in Africa among some influential opinion formers and political leaders. Some African doctors, intellectuals and journalists contributed to this impression. These debates, which came after the initial ‘where did AIDS come from?’ culminated in the refusal by President Mbeki of South Africa to accept that HIV had been proven as the cause of AIDS (see various issues of the *New African* magazine between 1995 and 2000).

dimension to the narrative.

The chapter then traces the unfolding of the HIV epidemic by subjecting this information to analysis and narrative.

4.1 What is HIV?

This section presents a brief account of what HIV/AIDS is, from a western epidemiological perspective. It is given to highlight the challenge that the arrival of HIV/AIDS might present to a medical system, traditional or western, as existed and still exists in Malawi.

The Human Immunodeficiency Virus (HIV) is one of the retroviruses. Retroviruses invade and replicate in human cells using an enzyme, reverse transcriptase for this replication. The commonest HIV-1 (previously called HTLV-III) is the type responsible for most HIV/AIDS cases in Malawi and most of the world. HIV-2, which is found in West Africa, is associated with fewer infected persons progressing to AIDS. It is thought that HIV-2 may either have a longer latent period or cause asymptomatic infection. The various strains of HIV differ in the nature of the viral envelope, a factor that complicates the formulation of a common vaccine (Makgoba, et al., 2002: 211). Some cases fitting the AIDS definition have been found where neither HIV-1 nor HIV-2 was present (Tierney et al., 1998: 1269). These findings have, given the prevalence of malnutrition and co-morbidity, contributed to the debates championed by Thabo Mbeki about AIDS being caused by malnutrition and other factors (Sidley, 2000: 1016). The present work takes the stance that sufficient research evidence has proved, firstly, the association between HIV and AIDS, and secondly, its communicable nature both in Malawi and the world in general (Taha et al, 1998; UNAIDS, 2000). It also, for the sake of argument, examines the 'HIV/AIDS epidemic', however caused, from the perspective of a communicable phenomenon with social, cultural and preventable dimensions.

The HIV virus mostly infects cells called CD4 (helper-inducer) lymphocytes, the cell

that directs other cells in the immune network. As the HIV virus reduces the number of CD4 cells, both the qualitative and quantitative ability of these immune cells to respond to infection is reduced. The HIV virus also affects beta lymphocytes and macrophages, cells that respond to infection by producing antibodies and swallowing invading antigen material respectively. Thus HIV infection produces both humoral and cellular immunodeficiency.

HIV infections were first found among USA homosexual men in 1981. As we shall see later in this Chapter, there have been a number of debates and controversies about the origins of the virus. There have also been differences in infectivity rates among different population groups. Some of these may be explained by nutritional and poor health services. The differences between Afro-American, Latinos on one hand and whites on the other suggests some biological racial factors or socio-economic and cultural factors. In Malawi, the pattern of HIV spread was from urban to rural areas and spread is mostly via heterosexual sex (about 80%), hospital blood transfusions and injections using unsterilised instruments, traditional practitioner use of unsterilised scarification tools and from mother to child (about 5-15%) (Cf. Lamptey, 2002: 207 - 11). Between 1981 and 1988, when the Malawi government began to take HIV infection more seriously, some observers, including the present writer, consider that hospital-acquired infections were more significant contributors to the toll (Cf. Gisselquist, D. et al., 2002:324: 235).

Ways of reducing HIV transmission

In the fight to prevent and contain HIV a number of ways of reducing factors and modes of spread have been identified:

- Better recognition and treatment of STDs
- Sexual abstinence
- Delaying the onset of sex among adolescents
- Having fewer sexual partners
- Safer sexual practices, including consistent correct use of condoms
- Supportive social environment to sustain behavioural change
- Reducing stigma and discrimination against those who are HIV infected
- The promotion of male circumcision

- Increasing resources for prevention and care
- Improving access to care and treatment
- Building the capacity in poor countries for an expanded and comprehensive response
- Caring for orphans and other marginalized vulnerable children
- Vaccination (Lamprey, 2002: 208 - 210).

In the Malawian context we can add

- The provision of safe blood for transfusion
- Safe sterilised hospital equipment
- Safe sterilised traditional practice equipment
- Reducing economic and social disparities which contribute to 'fatalism' (see Chapter Six)
- Anti-retrovirals for pregnant women and children
- Adopting perspectives that see HIV/AIDS as a social issue (Cf. Campbell et al. 2002: 229 –232)
- Adopting social and political attitudes that value each life equitably
- Recognising that cultural practices are usually maintained because they are viewed as appropriate to socio-economic circumstances.

Malawi cannot afford to fully implement most of the hospital preventive requirements because of resource restraints in the Ministry of Health (MOH). As the history of HIV/AIDS in Malawi unfolds these factors will be highlighted and examined in turn. Indeed one of the problems that faced African countries, once they had recognised HIV/AIDS, was, from a resource point of view, making clinical diagnoses that followed the American Centres for Disease Control (CDC) criteria. For adults and adolescents for example CDC had three case definitions:

- Definitive AIDS diagnoses (with or without laboratory evidence of HIV infection)
- Definitive AIDS diagnoses (with laboratory evidence of HIV infection)
- Presumptive AIDS diagnoses (with laboratory evidence of HIV infection)

Given that HIV testing facilities were, and remain limited, the accurate 'evidence' diagnosis of HIV became problematic and many cases of malnutrition and other causes of wasting were undoubtedly included. As Reeve and Wirima (1989: 137) noted

To 'diagnose' AIDS and satisfy the original US criteria requires diagnostic techniques not available in Malawi. A provisional WHO

clinical case definition has been suggested for use where facilities are limited.

The fact that when diagnosing AIDS many Malawi hospital practitioners were reduced, effectively, to the same use of phenomenological observations as their traditional practitioners is shown by the sophisticated laboratory testing required in investigating HIV/AIDS (Table 2):

Table 2 Laboratory investigations in HIV/AIDS

<ul style="list-style-type: none">• HIV enzyme linked immuno-sorbent assay (ELISA), which is 99.99% sensitive.• Western blot, a confirmatory test that can be affected by pregnancy and autoimmune diseases.• Full blood count which can show anaemia and loss of white blood cells in HIV infection• Checking CD4 counts. CD4 counts of less than 200 (normals are usually above 500) are associated with risk of opportunistic infections• HIV viral loads which measure the amounts of replicating HIV virus (viral loads of 5,000 – 10,000 copies per ml suggest need for treatment• Beta 2-microglobulin cell surface protein levels of above 3.5 mg/dL suggest macrophage-monocyte cell stimulation and are associated with rapid disease progression.• The p24 antigen is positive just prior to sero-conversion and with advanced disease <p>(Tierney et al, 2000:1279)</p>

Of these, apart from the episodic availability of HIV testing reagents, the only available tests in a district hospital, between 1981 and 1988, were those for Full Blood Counts. When it comes to treatment, the dire inadequacy of the Malawi health services is shown by the fact that CDC suggests the following protocol for HIV infected individuals.

Table 3 Health care maintenance of HIV-infected individuals

<u>For all HIV infected individuals</u>
CD4 counts and viral load tests, every 3 - 6 months
Regular Chest X-rays to catch and treat TB early
Checks for toxoplasmosis and cytomegalovirus
Pneumococcal, Haemophilus influenza B and influenza vaccinations
Hepatitis B vaccination for those susceptible
Six monthly cervical smears for women
Regular anal checks for homosexual men
<u>For HIV-infected people with CD4 counts less than 500</u>
Treatment with anti-retroviral therapy
(After Tierney, 2000: 1281)

For the average Malawian simple blood counts are not readily available, let alone CD4 counts and ‘regular chest X-rays’. Thus HIV/AIDS presented a formidable challenge to the precarious Malawian western medical services, services that already could not cope even without this added burden.

4.2 Origins

If the origins of HIV/AIDS are still mysterious (Karlen, 1995) its arrival in Malawi via the international road trade routes from the east - west (Congo/Kenya) and north - south (Kenya/South Africa) networks could be mapped out (Orubuloye et al., 1994) - if we accept the Congo/Uganda African entry point.¹⁴⁷ The 2 per cent prevalence rate among antenatal patients at Queen Elizabeth Hospital in 1985 (Taha, E. et al, 1998) and the work of L’Herminez et al. (1992: 113 - 117) suggests that HIV may have arrived in Malawi around 1977.¹⁴⁸ Oral Malawian discourses state ‘HIV/AIDS is new’ to Malawi:

¹⁴⁷ In March 2002, a survey of long distance drivers found that they were ‘among the main contributors’ to the spread of HIV in Southern Africa

(<http://allafrica.com/stories/printable/200203180886.html>)

¹⁴⁸ By extrapolation and by observing and analysing the patterns of illnesses and deaths among local

kwabwela Edzi (AIDS has arrived). A phenomenological observation of *imfa kuthamanga* (increase in [unexplained] deaths) occurred among urban young Malawian in the early eighties. The first hospital cases of HIV/AIDS, were described in 1985 (Cheesbrough, 1986) followed an increased incidence of Kaposi's sarcoma, a skin cancer now usually associated with HIV/AIDS in the Malawian context.¹⁴⁹ An early high profile HIV/AIDS case involved a beauty queen deemed 'presumably infected abroad' (Wangel, 1994: 22). The phenomenological observations were later to be confirmed by rising HIV positive rates at Blantyre antenatal clinics: 2.0 per cent (1985), 8.2 per cent (1987), and 18.6 per cent (1989) (Taha et al, 1998).

In the rural areas a similar *kuthamanga* (acceleration) of deaths, usually following a 'slimming disease' had been noted, and initially blamed on *kanyela*,¹⁵⁰ *tsempho* or *mdulo* illnesses (these are diseases resulting from breaking sexual taboos) (Kumpolota, Adini, Chipembere-Lwanda, personal communications, 2000). This concept of AIDS being blamed on *kanyela*, *tsempho* and/or *mdulo* illnesses by indigenous practitioners is getting belated examination by anthropologists (Cf. Wolf, 2001).

As elsewhere, HIV/AIDS was initially been blamed on 'high risk' groups. Banda's stance against Western 'immorality and decadence', though – interestingly, at least in public - not homosexuality, was well known.¹⁵¹ But homosexuality, at least as practices like sodomy, exists in Malawi, in prisons (Mwangulube, et al., 1997), schools and labour camps.¹⁵² Malawian elite joined the pan-African objections to 'HIV pathologising' Africa due to its 'wanton sexuality' facilitatory of HIV spread (Caldwell et al., 1989). In the binary atmosphere of these debates Malawian elites, like Banda, resorted to traditional culture, actual or remembered: in pre-colonial Maravi culture, for example, 'adultery was the fault most severely punished' (Stannus, 1910: 299).

and external based Malawian students for example. The earlier causes of death were replaced by illnesses associated with weight loss.

¹⁴⁹ Kaposi's sarcoma occurs, much less frequently in HIV negative patients.

¹⁵⁰ *Kanyela* results from 'having sex with a menstruating woman; having sex with a woman who gave birth recently; having sex with a woman who has had a miscarriage; or having sexual intercourse with a person with *kanyela*.

¹⁵¹ See Banda's speeches for 1961 – 1971.

¹⁵² Rangeley (2000: 38 – 39) records the occurrence of both buggery and sodomy in colonial Malawi Chewa. See also Murray and Roscoe (2001) for African context.

Malawians claimed that AIDS ‘American Invention Depriving Sex’¹⁵³ or *matenda aAmerica* (the American disease) was an ‘American’ family planning plot. Family planning was anathema to both Banda and traditional male culture (Malawi National Family Planning Strategy (NFPS), 1994: 2 -4). HIV arrived at a time when Banda’s ‘peaceful state’ could not accommodate dissent, even by a disease. Public sexual prudery, with strict Censorship and Dress Codes, contrasted with the Malawi Congress Party (MCP) culture’s female sexual exploitation (Mkamanga, 2000) which contributed to HIV spread. For Dr Banda’s Malawi, as for most of sub-Saharan Africa at the time, Mbembe’s observation, despite a degree of overstatement, is appropriate:

... sex and gender norms have historically been central to the structure of power relations and to the organisation of cultural categories in Africa. The role sexual pleasure plays in contemporary struggles for public power, cultural influence, economic life, and class categories, is, in most contexts, astounding. Sexuality is entangled with broader questions of lifestyle, pleasure, happiness, risk, and death; with the aesthetics of the body; with desire, sensuality, fecundity, and subjecthood. It represents the most important site where new African identities are staged, performed, and enacted (Mbembe, 2001: 7).

We note however that this sexual power, at least in Malawi, is controlled by various taboos, traditional or, in political cases, neo-traditional.

For different reasons, both traditional and western medical spheres delayed in responding to the epidemic. Public health officials sent out signals, which ignored realities, e.g., cultural attitudes and the cost of condoms; by 1997 only 21 per cent of females had ever used condoms (Namate, et al., 1997). Using ‘undigested and uncontextualised’ western HIV prevention strategies insured that condoms rapidly became linked to ‘the deprivation of pleasure’, forced family planning and Western values. Many family planning expatriate workers emphasised the two or three children per family model, often without understanding the reasons for the traditionally large families.¹⁵⁴ Those initial few who accepted condoms were seen, because of their breaking with local customs, as promiscuous.

¹⁵³ This stance was part of a pre-HIV anti-American discourse related to the Vietnam War, and perceived American/western imperialism. For a flavour of this discourse see for example www.conspiracyplanet.com/channel.cfm

¹⁵⁴ The more children a poor family has, the more are likely to survive famine or epidemic illness.

Traditional practitioners in Malawi lacked the [pre-colonial] ability, from their localised bases, to observe the magnitude and extent of the HIV epidemic; like the scientists, they required time to understand the epidemic. And, coincidentally, the initial ‘slim’ presentation resonated with witchcraft and sorcery causation. As the young, educated potential wage earners mysteriously slimmed and died, jealousy and witchcraft were often cited (cf., Police Orchestra’s song *Mwana wanga Koli*, My daughter Koli).¹⁵⁵ Doctors and some *sing’angas* had noted that women succumbed at much younger ages than men.¹⁵⁶ Research later confirmed that between ages 15 to 19, 85 per cent of AIDS patients were female; beyond age 30 ‘men predominate’ (King and King, 1992: 163).

4.3 Names, meanings and impotence

One of the first national responses was choosing a local name for AIDS. In traditional contexts, sexually transmitted diseases had encompassing communal aspects, mirroring the transgressive element of some sexual activity as shown by diseases like *kanyela*, *mdulo*, and *tsempho* [diseases caused by transgressing sexual taboos] (Drake, 1976). And STDs still ‘account for a significant burden of health services in Malawi (Daly and Liomba, 1998: 46 – 49).

The name finally chosen, or rather ‘imposed from above via radio’¹⁵⁷, after little debate was *Edzi*, an onomatopoeic Chewaising of ‘AIDS’. *Magawagawa* (‘something shared’ after *kugawa* to share) (*Moyo* magazine, 1986) had briefly been in vogue; as had *chiwerewere* (promiscuity). Both had the advantage of invoking ‘communicability via promiscuity’. However, western trained health workers lost the opportunity to communicate with their rural compatriots the already known sexually transmitted dimensions of HIV/AIDS by merely opting for translating AIDS onomatopoeically, as is commonly done with foreign words, perpetuating the ‘non-communicative’ cultural duality. The HIV virus became *kachirombo ka Edzi* (the wee AIDS beast). In Malawi

¹⁵⁵ In the song, Koli, the expensively educated daughter, was killed in her prime by jealous neighbours’ *ufiti*.

¹⁵⁶ Based on personal communications and observations from 1985 to 1995.

¹⁵⁷ ‘Tinangomva akuti basi Edzi. Ndim’mene zinali kale lija’. (We were merely told [the new disease is called] AIDS. It was like that in those days) (Tembo, Oral interview 8/7/2000)

concepts of causality AIDS was now, unwittingly, a ‘curable disease’: remove the wee beast [however originated] and the disease is cured. While the germ theory is significantly recognised the singular *kachirombo* encouraged some patients and traditional doctors towards the ‘curative removeability’ of *kachirombo*, a belief still current (Lwanda, 2000). Msiska (1981: 186), in his paper on the *Virombo*, *Vimbuza* and *Vyanusi*, (diseases caused by spirit possession) defines *virombo* as ‘a kind of bodily illness associated with spirits of *vyanusi*... conveniently refer[red] to [...] as evil spirits...’. A *chirombo* patient being a less serious case than a *vimbuza* one, and a *vyanusi* being more serious than the other two... *Vimbuza/virombo* or *mashawe* [spirit possession] diseases are some of the most well known and lasting concepts in traditional medicine (Chilibvumbo, 1972b; Soko, 1985). Significantly, the cure of these diseases involves the exorcising of the causative spirits. In 2000, my field studies showed *Sing’anga* Kumpolota still practising healing *Virombo* using these concepts at Likoma. This spirit possession model was recruited by some into the HIV/AIDS discourse because of the *kachirombo* concept.

The continued minority use of *chiwerewere* (promiscuity) suggests an understanding of the sexually transmissible nature of HIV. Contextually, the choice of the meaningless *Edzi*, the vague epidemiological and treatment options, the family planning suspicions and the heavy-handed approach of Dr Banda’s government, which kept repeating the ‘there is no HIV cure’ message, led to HIV/AIDS being named the ‘government disease’ (*matenda a boma*) (Kanjio, 2000).¹⁵⁸ This concept persists and recalls the earlier ‘superior European’ medicine *mankhwala achizungu* (European medicine) debates. The question, then often asked by ordinary people, was: ‘How can there be no cure [from the superior European medicine/government?] This is a family planning plot!’ (Kanjio, Oral interview, 5/7/2000; Cf. Schoffeleers, 1999).

The association between shingles and AIDS was another feature that endeared itself to the traditional causality theory. The phenomenological establishment of an association between the heralding shingles, the ‘slimming phase’ and deterioration into death

¹⁵⁸ One heard similar comments from patients on the methadone programme in Scotland. Some described methadone addiction as the ‘government disease’ (Hamilton, personal communication, 26/5/01).

quickly evoked sorcery, and some who got shingles did not die.¹⁵⁹ But there was a socio-economic issue here.¹⁶⁰ In 1994, the period between the shingles and 'terminal' AIDS varied from a few months to 10 years depending on nutritional status and other variables. Those likely to die early were the HIV positive youth with poor nutritional status or unhealthy lifestyles due to poverty or pre-HIV infection illnesses. Phenomenologically, obesity, as of the old Maravi and Bantu, became a sign of good health and 'slimness' indicative of disease.¹⁶¹ Shingles, with its 'hot' blisters, became the harbinger of AIDS, a time to seek medical help. As western medicine was unavailable palliative, many resorted to traditional medicine. Shingles, though resonating with leprosy in its 'heat' did not, between 1985 and 2000, in rural areas, fan the HIV 'segregationist' discourse of urban areas,¹⁶² perhaps suggesting HIV/AIDS taboos were yet to emerge. This was possibly because the HIV-associated shingles, despite the severe pain and debilitation, usually resolved. And, as with leprosy, in life and death, HIV/AIDS victims received good community care.

Between 1985 and 1993, medical discourse emphasised the mystery of and lack of cure for HIV/AIDS (*MNACP Manual, 1989*) and a strong religious lobby considered 'immorality' and God's resultant 'wrath' responsible for the epidemic (Catholic Church, 1991). Neither view contradicted putative traditional medical practitioners' early theories on the emerging epidemic. As missionary hospitals provide half the medical services in Malawi and run many schools, a significant Christian point of view was leveraged on the HIV/AIDS debate (Schoffeleers, 1999). Some Christians, although decrying HIV promoting cultural practices, approved 'conservative' or formative aspects of African Traditional Religion (ATR) (Catholic Church, 1991: 51 -

¹⁵⁹ Shingles, a disease caused by the *Herpes Zoster* virus, is an old disease. However, it occurs much more frequently in HIV positive patients, usually at the stage when the asymptomatic HIV positive status begins to be associated with immune deficiency symptoms.

¹⁶⁰ The period between HIV infection and progression to terminal AIDS varies from person to person and depends on the presence or absence of coincidental illness, state of nutrition, ability to access treatment, living conditions and other variables.

¹⁶¹ Among many Southern Bantu cultures, obesity, especially among women, is usually a desirable feature. This is true of the Yao, Chewa and Tumbuka.

¹⁶² Although AIDS victims are well looked after and nursed, this nursing is usually left to women and/or servants. In urban areas it is common for AIDS relatives to be sent home to the rural areas for terminal nursing. Stigmatisation of HIV/AIDS sufferers is manifested by discourse like *matenda omwewa/zomwezi* (that disease). AIDS patients are usually found in crowded and unsanitary wards.

53).¹⁶³ Forster (1998, 537 - 545), for example notes that the churches, through the Christian run schools, had a lot of influence in the school syllabus and were influential in pushing the line against condoms.¹⁶⁴ He noted that Muslims were more pragmatic. Eventually, in 2000, the conflict between the Christians and Muslims for the dominant role in the syllabus reached a crisis, temporarily solved by President Muluzi's intervention.¹⁶⁵ And the multi-sectoral debate between the religious organisations, the state and ATR, was to continue until a state sponsored 'summit' meeting in February 2001 (Ott, 2001).

Academics, researchers, religious leaders and others have usually discussed the psychosocial aspects of HIV, in terms of 'fatalism' or 'unexplained high risk behaviour'. Forster (1998), from research in Zomba, for example, while aware of the multiple causality paradigms, attributes more to fate than his study perhaps suggests; people who 'do not fear AIDS because they have medicine' do recognise that AIDS can be fought. The apparent fatalism is a function of available economic, social and leisure alternatives. Msukwa et al's (1994) observation of high death rates in young adulthood was related to the basic inadequacies of health services. Further, the idea of 'divine punishment' is common to ATR and Christianity and also resonates with the idea of 'transgressing taboos'.

In 1985, as we see later, while these competing discourses intensified and unravelled in political, religious, economic and cultural directions a simple medical statistic helped to concentrate the little efforts then available.

4.4 Cultural Practices usable in HIV/AIDS Prevention

In Malawi, HIV spread is largely via heterosexual sex. Many cultural forms normal to rural Malawians are considered problematic by 'westerners' yet many are promotive of good health in the context of rural Malawi (Mwale, 1977; Peltzer, 1986).¹⁶⁶ Despite the extensive polygamy discourse, monogamy dominates. However, both postcolonial

¹⁶³ Such as obedience to elders and avoiding breaking taboos.

¹⁶⁴ In my questionnaires, the preferred method of HIV prevention was usually given as 'abstinence'.

¹⁶⁵ Astutely, he merely postponed the decision on the new syllabus, diffusing the situation.

¹⁶⁶ In terms of reducing premarital sex, reducing communal tensions and preventing *mdulo* and *tsempho* (sexual disease caused by transgressing taboos).

presidents have supported polygamy as an 'African custom'. Banda publicly supported Inkosi ya Makosi (Paramount Chief) Mbelwa's polygamy (Ngulube-Chinoko, 1995: 92). Only 21 per cent of marriages are polygamous according to the Demographic Health Survey of 1992.¹⁶⁷ Traditionalists argue that practices like polygamy and *lobola* (bride price) ensured that extra and pre-marital sexual practices were minimised, and men 'valued' women. Initiation ceremonies, like *chinamwali* and *nsondo* were, they argue, 'a healthy form of health promotion' and minimised pre-marital sexually experimentation. Elders 'controlled society' and taboos 'enforced' fidelity: *kutsekereza* (act designed to prevent intercourse in spouse's absence) could 'ensure a spouse's fidelity' during one's absence. Taboos on illegitimate children minimised premarital sex. For example, among the Nyanja of Malindi, an unmarried girl at the most painful part of labour was forced into revealing the father by being told she 'could not deliver' unless he was named. This ensured that the man responsible faced the consequences. The complicated system of *ankhoswe* (marriage guardians) means that there are people able to mediate in marriage disputes, minimising chances of divorce or separation.

In traditional Chewa law (Rangeley, 2000: 34 – 35) it was an offence to 'rape or cohabit' with an unmarried nubile woman; the guilty man was obliged to marry her or he faced a *chipongwe* (insolence) charge. Similarly, adultery 'was formerly a most serious offence' (Rangeley, 2000: 35). And until a girl had been through initiation, *chinamwali* (among the Chewa) or *nsondo* (among the Yao) she was not allowed to have sexual intercourse. Laws also existed to prevent sex with children. A man or post initiation adolescent youth indulging in sex with her was [said to have] *wakawa* (destroyed her) and faced *mlandu* (prosecution) (Rangeley, 2000: 36 - 37). The same held for a woman having sex with a pre-initiation boy. And, among the Chewa, sex between a man 'his mother, his sisters, his nieces by his sisters, his maternal aunts, the daughters of his maternal aunts, the wives of his paternal uncles, his maternal grandmother and his own daughters' (Rangeley, 2000: 39) was illegal. The guilty person here committed *kukashusha mbumba* (destroying the family), an act associated

¹⁶⁷ The National Statistical Office, 2000b gives a polygamy rate of 21% for the whole of Malawi. The practice of polygamy (*mitala*) is found in most parts of Malawi. It is a practice intended to curb infidelity 'because the man has more than one wife and so would see no reason to go out with other women' (Kondowe et al, 1999). Since the advent of HIV/AIDS, as neither the husband nor the new partner are HIV tested, three, or more people are put at risk. *Mitala* (polygamy) is common in the Northern and Southern regions.

with *ufiti*. A woman having sex with men on the prohibited list was not charged with *ufiti* but was thought of as *mbunduzi* (a very bad woman who breaks the village), *chitsilu* or *chilekwa* (a fool). As far as married women were concerned, it was a *mlandu* (prosecutable transgression) to solicit adultery with a married woman (*kutongoza*) (Rangeley, 2000: 51); and persistent adulterers were banished or sold into slavery (ibid: 28).

The whole range of *mdulo*, *tsempho* and *kanyela* (Drake, 1976; Morris, 1985, 14 – 36; Rangeley, 2000: 40 – 50) taboos were designed to control sexuality and minimise, if not abolish extra marital sex, infidelity and marital and hence communal breakdown.

My own view is that traditional family values, a nebulous but identifiable concept, can - when communally imposed and able to be voluntarily imposed - promote the security and stability of the extended family, offer orphan care, minimise destitution and prostitution and facilitate fidelity via the ‘transparency’ of a communally legitimised marriage. Among the many traditional practices, which may look unsavoury at first glance, are residues and kernels of pre-colonial public sexual health measures. Abandoning these without substituting positive, sustainable and meaningful alternatives can only cause a resistance that drives the practices underground. Wamui (2001) makes a similar point about the persistence of clitoridectomy among the Kikuyu despite the criticisms of Christianity and the forces of modernity.

As we shall see in Chapters Five and Six, many of these practices remain appropriate due to the socio-economic imperatives still prevailing in Malawi.

4.5 Cultural Practices Conducive of HIV Spread

A United Nations’ Educational, Scientific and Cultural Organisation (UNESCO) inter-regional conference held in October 2000 in Nairobi, Kenya, identified a number of key ‘cultural features’ of relevance in HIV/AIDS prevention, treatment and care in Central and Southern Africa.¹⁶⁸ These were given as:

¹⁶⁸ Countries involved included Tanzania, Namibia, Zimbabwe and Uganda (Inter Press Service,

- **INDIVIDUAL BASED**
Premarital sex; Extra-marital sex; Infertility; Forced sex; Sex for pleasure; Life skills; Fatalism; Poverty; Unemployment and Migration.
- **FAMILY BASED**
Extended families; Forced marriages; Widow inheritance; Domestic violence; Gender relations; Female genital mutilation (FGM) and Unemployment.
- **COMMUNITY BASED**
Complacency; Discrimination; Fears and stigma; Social exclusion; Traditional healers and medicine; Perception and interpretation of illness; Illiteracy; Poverty; Herbal medicine; Crime; Alcohol and substance abuse
- **INSTITUTIONAL COOPERATION**
Religious institutions and leadership; Cultural leaders; NGOs and Decentralization (UNESCO, 2000).

The report adds:

These country assessments have revealed important advancement in the use of the cultural approach to health development. The Conference has noted that cultural factors can be used to mitigate the impact of HIV/AIDS, if effectively integrated policies and programs are focused at individual, family, community and at national/international levels. Pilot and case studies have shown that interventions at these levels can make significant improvement in the fight against HIV/AIDS (UNESCO, 2000).

The report shows that cultural factors cut across personal, family, community and institutional lines. Where culture is a major plank in institutional and community relations and cohesion the sensitivities of institutional, political and cultural power brokers need to be taken into account when challenging any cultural activities in HIV/AIDS battle.

In Malawi, initiation ceremonies have been the main targets of criticisms, blamed for promoting early sex between boys and girls and between men and young girls (Chaima, 1994) and for early marriages and divorces (Chiwaya, n.d.). Some initiation ceremonies, for example among the Central region Chewa, involve a *fisi* (man tasked with anonymously deflowering the virgins).

October 11, 1999).

However, the main cultural contributor and key to promoting HIV/AIDS is women's weak societal position.¹⁶⁹ This has been noted in other parts of Southern Africa (Akeroyd, 1996; UNIMA/SARDC, 1997). Consequently there are many practices that remove choice from them, forcing them into high-risk domestic activities – for example, polygamy among the Yao and Chewa; arranged marriages among the Nyanja and widow inheritance (*chokolo*) among the Ngoni – which compound the problem. Other male centred cultural practices (Cf. Kamwendo, et al, 1999; Tembo et al, 1993) privilege males. As Kondowe et al noted:

... nursing the sick a task which the study says is left primarily to women because of their supportive social roles associated with serving the family; death rites whereby a woman who has been widowed is required to have sex as a cleansing ritual before and after the burial of her husband; property grabbing in which a widow's property is grabbed by the male relatives and she is left to fend for herself sometimes through 'commercial sex'; widow inheritance, a practice in which a widow is inherited by the brother of the deceased exposing either of them to HIV infection; and polygamy a practice which allows men to marry more than one wife - no HIV testing is done. Traditional medicines and witchcraft sometimes prevent rational scientific understanding of HIV/AIDS because many communities believe that HIV/AIDS can result from magic and that it can be treated by herbal medicines. In some cases when a woman has problems especially in bearing children, a witch-doctor might have sex or recommend that she should have sex with somebody else as part of the healing process (Kondowe et al, 1999: 5).

This male dominance extends to exposing powerful elite women to HIV through the sexual behaviour of their men folk who have mistresses. Thus 'high socio-economic status is, [among women] in Malawi, a risk factor for HIV-1 infection' (Dallabetta, et al. 1991).

¹⁶⁹ Women suffered a number of disadvantages, in relation to HIV/AIDS as a result of their lower status in society: Under the custom of widow inheritance or *kuhara*, common in the Northern region, a woman is inherited by the brother of the deceased which may expose either of them to HIV infection. Girls are at a disadvantage because many parents feel that it is, culturally, better to educate a boy than a girl, the latter moves to her husband's family on marriage, whereas the male remains, financially, part of 'the family'. Girls, as a group, are therefore less educated than boys.

Men who refuse to use condoms (Namate, et al., 1997) in all parts of Malawi force women into unprotected sexual practices. The refusal to use condoms is a culturally predicated phenomenon:

Cultural views about sex are such that sex [unprotected] is seen as the greatest drive for marriage. It is a very important social factor and is more for procreation and personal gratification than for love. It is considered natural and unavoidable, particularly for men such that manhood without sex is considered incomplete. (Kondowe et al, 1999: 12).

The refusal to use condoms is allied to the preference by some for 'dry or tight sex'. The use of vaginal tighteners in all parts of Malawi can cause Sexually Transmitted Disease facilitating vaginal injuries.

Other practices that are considered culturally normal can spread HIV by legitimising high-risk behaviour. These include: *nthena* (widower given wife's younger sister in the Northern region); *m'bvade* (unmarried female's post-natal abstinence is concluded by surrogate sex in the Southern region); the use of *fisi* (surrogate) in male infertility in most ethnic groups; the use of *fisi* in initiation rites among the Yao; and the belief that STDs, including HIV, can be prevented with charms and 'vaccines'.

4.6 Activities and agendas

It was the finding of a 2 per cent HIV positive rate among 200 pregnant women in a May/June 1985 USAID funded survey (Chiphangwi, et al., 1988) that galvanised health workers and donors, culminating in the setting up, in October 1985, of a committee to 'ensure that blood for transfusion was safe'. HIV screening facilities at Queen Elizabeth Hospital (December 1985) and Lilongwe Central Hospital (Feb 1986), funded by German aid, resulted. But the Germans' generosity ensured that HIV seropositivity figures, that would have been normally censored, came out of Malawi; they were required to justify further donor HIV funding (Wangel, 1995: 24).

This donor funding enabled the establishment of a National AIDS Secretariat responsible to Hetherwick Ntaba, the Ministry of Health (MOH) Permanent Secretary, and Banda's personal physician. Ntaba approved all Malawian staff at the Secretariat and at WHO regional office, ensuring that all Secretariat activities were visible to the Office of the President. Yet it took until 1987, before the MOH formulated the First National AIDS Campaign Programme and four years before the National AIDS Committee (NAC) resulted in 1989. The first short-term plan, of 1987 was mainly designed to ensure the screening of blood prior to transfusion. It is worth noting that in 1987, *A ten-year plan of action on medical research* in Malawi, while including STDs in priority areas, did not mention HIV/AIDS (HSRC, 1987: 1 – 2).

The NAC was politically handicapped from the start; Ntaba and his superiors controlled and politicised decision-making.¹⁷⁰ Local staff members, politically excluded and denied access to the donor funds, were reluctant to input ideas (cf. Liomba, in Wangel, 1995: 26). This was for several reasons. First, they could get into political difficulties for suggesting politically unacceptable initiatives. Second, they were excluded from seminars or better paying jobs and third, in most cases they knew more about the local aspects of the subjects than their better paid expatriate colleagues who usually took credit for the work (Cf. Carr et al, 1993: 1 - 8) and felt resentful. AIDS research was initially not encouraged. Expatriate led research only began to fare better when the 'statistics for funding' imperative intervened.¹⁷¹ As the donor facilitated HIV seropositivity rates started to emerge they strengthened the hand of local and expatriate medical workers at the frontline of clinical work.

This donor initiated 'HIV figures for funding' imperative subverted the government's apathy. Other factors included: the specific German HIV-testing involvement;¹⁷² the WHO/donors' impetus; the deaths from AIDS of key civil servants and politicians

¹⁷⁰ The political handicap was because Banda's lieutenants did not, at most times, want or dare to rock the boat and upset him with initiatives that might go wrong. Consequently they tended to, as a former Party Secretary General once put it, 'sit *phwii pa mpando wonona*' [sat comfortably and procrastinated] on difficult decisions either until Banda acted or spoke, or donors intervened. For Banda's temperament, see Short (1974: 200). I am also grateful to Fergus McPherson for insights into Banda's temperament (Personal communication, 8/7/98).

¹⁷¹ In order to get WHO and other donor funding, the NAC and Malawi government needed to show how many people were HIV positive.

¹⁷² Some of the earliest HIV testing was done in Germany.

between 1985 and 1988;¹⁷³ the Malawi Army's Mozambique involvement, particularly from 1986 – 1990; the increased HIV/AIDS burden on hospitals (Cf. Forsythe, 1992), especially after 1990 - 1993; the political impact of the escalating rural funerals on the democratic transition of 1991 - 1994;¹⁷⁴ and, as in colonial times, the ruling elite self-interest including the paranoia about Banda being exposed to HIV by his servants.¹⁷⁵

But even so the NAC was not, initially, a vibrant body. Its first two initiatives were of a limited nature; the first concerned with testing blood for transfusion and the second expanding health education and information initiatives.

It was largely the donors' (WHO, USAID, UNICEF and EEC) promises of funding which forced a change of pace (Wangel, 1995: 27). The NAC's 1989 - 1993 medium term plan for the 'prevention and control of AIDS in Malawi' (MOH, 1989) was 'the basis of requests to donors for assistance'. The state and individuals in the neophyte 'HIV/AIDS industry' realised that the HIV problem could be exploited to secure scarce foreign exchange for research and service provision.¹⁷⁶ The diversion of fridges and video machines meant for HIV work from UNICEF to civil servants and MCP officials between 1988 and 1989 (Cf. Wangel, 1995) has been held as a visible example of this individual gain from the HIV problem.¹⁷⁷ Further, the Malawian 'seminar culture' ensured that local workers obtained better income through attendance at donor funded seminars than from their own jobs. At state level, money meant for AIDS work was sometimes diverted to national coffers to cover foreign exchange shortages. From 1988 the government abused donated test kits - commandeering an entire shipment in 1991 (Wangel: 30 - 32). The 2,000 'state house' staff were tested annually when there were

¹⁷³ This was noted particularly by the IMF and other international agencies that were interested in 'capacity building in Malawi' (Cf. Fredland, 1998: 547 – 568).

¹⁷⁴ This became an important cultural issue. Muluzi, Banda's successor, made much of this and earned himself the sobriquet '*Pulezidenti wopita kumaliro*' (the President who [cares enough] to attend funerals).

¹⁷⁵ Banda was always fastidious about personal health and appearance (Cf. Short, 1974). In the Malawian context, his smart appearance was typical of a Tonga 'smart dresser' (Lwanda, 1993). The expulsion of Malawian workers from South Africa, in 1988, after HIV positivity rates of around 10% were noted appears to have been a factor.

¹⁷⁶ A number of donor-funded initiatives have, in the Malawian context, been exploited by elites for the foreign exchange they generate. Cf. the Mozambique refugees (Lwanda, 1993: 146) under Banda, and Somali and other refugees (1995 – 2002).

¹⁷⁷ During the 1991 – 1994 transition this diversion of resources from the public to the private arena was called 'stealing' by the opposition groups (cf. *kuba mankhwala* - stealing medicine – a taboo in Maravi culture).

insufficient kits for blood transfusion work in hospitals and the government was minimising the AIDS problem. This was reminiscent of the colonial 'Europeans only hospitals' and good care for 'elite' African workers. Part of the NAC's handicap was its realisation that one of the contributors to the AIDS epidemic was the government itself via the use of unsterile equipment in its hospitals and clinics. Yet this message could not be strongly conveyed without invoking the political wrath of the government. Later M'Bamba (1991) reminded his fellow workers that 'unsterilised injection needles can spread HIV/AIDS' and called for ways to minimise this risk.

The next initiative, termed the Medium Term Plan, spanned the period between 1989 and 1993. This phase began to emphasise information, education and communication (the so called IEC) strategies. In terms of outcome, this has been the most successful phase of the NACP; it has delivered high HIV awareness levels. The next Medium Term Plan (1994 – 1998) was designed to develop a multi-sectoral approach to the HIV/AIDS. This phase has been the least successful, for the reasons we describe later in this and Chapter Five.

Dr Liomba's arrival, in 1991, raised the NAC's profile and some media discussion of HIV in Malawi ensured. This was for a number of reasons. He was the first senior Malawian doctor, a consultant pathologist, to occupy the post; the previous incumbent had been a non-specialist. He was perceived as being independent of, and capable of standing up to, Ntaba, the Minister of Health, and most importantly, was aware of the cultural implications of the epidemic. And, coincidentally, his appointment coincided with the 1989 - 1991 impetus for political and economic change. This was a period when some senior civil servants and NGO's - emboldened by factors like 'donor funding for human rights' and the severe poverty and famine - were beginning to subtly stand up to the Banda government.¹⁷⁸

At this period, following the 1988 – 1989 skirmishes between the donor agencies and

¹⁷⁸ During the 1988 – 89 donor/government negotiations, for example, some NGO officials openly disputed the government's denial of a famine (Claver, G., Personal communication, January 1992). Banda's government was obsessed with the preservation of an image of peace, order, contentment and perfection.

NGOs and the government,¹⁷⁹ family planning NGOs, like *Banja La Mtsogolo* (Family of the Future) BLM, began to assume a higher profile. Government publications, like *Moyo* and the *Malawi Medical Journal (MMJ)* increased their coverage of HIV/AIDS. An exponential increase in research on HIV in Malawi is noticeable from 1988 – 1989 (Centre for Social Research, 1999).

Meanwhile, the donor initiated monitoring had shown rising HIV seropositivity rates: for example 21.9 per cent (1990) and 31.6 per cent (1993) at the Queen Elizabeth Hospital antenatal clinic. By 1993 some rural areas' antenatal clinics had HIV-positive rates of 12 per cent (Chilongozi et al., 1996).

Beginning in 1990, urban and rural surveys demonstrated that people 'were [becoming] generally aware of the AIDS problem but lacked specific knowledge of causation' (Kishindo, 1990). Among school teenagers only 67.1 per cent could be graded as 'moderately knowledgeable' (Msapato, et al, 1990). This suggested that information on HIV/AIDS was clearly being effectively disseminated about the presence of HIV/AIDS, but not about the causes and prevention. This high communal awareness of an incurable disease, without specific knowledge of prevention may have contributed to the 'fatalism' by engendering an atmosphere of inevitability (Cf. Forster, 1998, McAuliffe, 1994); especially as acquiring Aids was presented as a death sentence. In 2000, one of my student respondents (Kalugwile, C. age 15, [35]) stated:

I know AIDS is a very dangerous disease. Once you get HIV/AIDS, just know that you have dug your own grave, you are going to die.

Knowledge of impending death would tend to encourage high-risk behaviour. Significantly, 'prostitution', which is viewed as a 'female occupation' in Malawi, was identified as the major 'transmitter' quite early on (Cf. Kishindo, 1995). This, the earlier female HIV/AIDS presentation and mortality and the low female social status compounded the cultural stigmatisation of women. Some traditional practitioners,

¹⁷⁹ In a number of meetings with government ministers and civil servants, unlike in the past, donor agencies and locally based NGOs had, informed for example by accurate research statistics from the Centre for Social Research (Cf. Roe et al, 1989), 'stood up' to the government, refusing to accept the latter's reassurances that all was well (Claver, personal communication 3/1/92). External researchers at the Centre for Social Research facilitated the flow of research material to donor agencies.

instinctively reacting - as all medical people do - to a new disease, possibly influenced by the 'slim' pattern, or the widespread 'western' ignorance of the 'viral cause', either sought to 'cure' the disease by removing *kachirombo* (the virus) or resorted to witch finding, neo-taboo formulation and other 'marginal' activities.¹⁸⁰ The more western practitioners condemned these traditional approaches, the more biomedicine's own helplessness, at least from the rural perspectives, was exposed (personal observations, 1994). In their 'helplessness', both camps seemed to scapegoat culture.

4.7 The Role of Dr Banda's Government

In failing to take note of these, and many other, cultural attitudes, beliefs and social conditions conducive to HIV spread both postcolonial administrations can be accused of negligence. As Banda's government was in charge at the onset of HIV/AIDS, it, initially, faced the greater charge. At the very least, the postcolonial social conditions of pervasive poverty dictated a reappraisal of the western 'condoms' approach. This neglect can also be argued at the 'conspiracy' (Cf. Wangel) or default level. The diversion of testing kits to HIV test Banda's State house staff would on its own invalidate the 'default' argument. Government workers, advisers and policy makers were aware of the magnitude of the HIV epidemic. That they could not act positively and swiftly is perhaps a function of the paralysis in government systems that the Banda regime engendered.

Even if there was negligence by default, a case for the state's active 'cultural' contribution to HIV/AIDS spread can be made, beginning with the failure to promote health education, in general, and STD prevention specifically, from 1963 onwards. In reviewing the literature, Msukwa (1981: 1 - 63) found that there had been no health planning, by Dr Banda's government, prior to 1971. After two initial plans (by Cole-King in 1968 and Maurice King in 1969 respectively) were ignored, the government brought out its own *Malawi Development Plan for the period 1971 - 80*. This was a policy document stressing the building of hospitals, an echo of the colonial emphasis on curative services for those in employment. This measure ignored the rural areas and

¹⁸⁰ Many 'remedies' were suggested, such as having sex with virgins, various diets and herbal drinks, scarification with unspecified medications and, most notably, *mchape*.

downgraded prevention and health promotion. A WHO report in 1972 then proposed the setting up of a health system based on primary health care. This had elements of Maurice King's ideas.

Msukwa, unusually for the time, criticised the lack of policy goals and the lack of health education. He felt that 'of all these activities, the most important one is health education which aims at altering behaviour where it causes disease, and this is the activity most neglected in Malawi...' (Msukwa 1981: 30) One of his regrets was the postcolonial government's tendency to ignore traditional medicine.

It is not very common to include traditional medicine in a discussion of existing health services but I feel that traditional practitioners play such an important role in the society that not to discuss their contribution is a mistake (Msukwa 1981: 39).

And resolutions from the National Seminar on Primary Health Care (MOH, 1978: 86 - 92), about cooperating with traditional practitioners, were not followed up. Dr Banda, who apparently saw labour as one of Malawi's main resources,¹⁸¹ banned family planning until 1982, and then only allowed 'child spacing'. Child spacing was, in the context of the Banda's anti-family planning tendencies, a hazardous pursuit for practitioners (doctors, nurses, family planning workers) and their patients.¹⁸² Chipangwi (1985: 113) attempted to clarify the issue:

Malawi uses the common law principle that if an activity is not prohibited by law then it is legal; this is strengthened when government pronouncements state a particular activity is acceptable to the government.¹⁸³

¹⁸¹ In many speeches he declared 'my people' and 'the soil' as Malawi's greatest assets (Cf. Banda's Speeches 1964 - 1975). John Tembo, the Finance Minister (and Reserve Bank Governor) for a large part of Banda's rule, also extolled the virtues of migrant labour in Malawi's development (Cf. Chirwa, 1988: 53 - 79; CIIR, 1993: 15).

¹⁸² Child spacing was defined as '... the interval between one pregnancy and the next. The ideal interval is one that permits the first infant to be both independent of breast milk and be able to walk before the next one arrives. Malawi recommends an interval of three years (Chinyama, 1986: 10)'. Cf. UNICEF/Malawi Government, (1986: 37 - 39).

¹⁸³ Chipangwi was the senior gynaecologist in Malawi in 1985.

This child spacing programme was based mostly on the use of the contraceptive pill, injectable contraceptive hormones, the rhythm method and abstinence. It was largely female based, with little condom use by males promoted. The slow development of family planning services is shown by the fact that by 1994, thirty years after independence, 'only 43 per cent of the 756 static health facilities provided family planning services', as did 'only 11 per cent of the 1169 Mother and Child outreach services'. Inadequate finance and resources were blamed for this state of affairs (NFPS 1994 - 1998, April 1994).

The NFPS (1994 – 1998) informed by the high maternal and child morbidity rates, placed reduction of the 'natural population growth rate' above 'the reduction of communicable diseases'. The half-hearted and under-resourced attempts to bring traditional birth attendants into the national system were not consolidated. The postcolonial failure to empower and utilise village health committees, as 'democratic' 'motivating factors' in mobilising rural people' in 'social change' (Tembo, 1993: 43) was to privilege the dominant village hold of traditional medicine. A little studied phenomenon, in the Malawian context, is the demographics of male/female ratios in urban areas. In Malawian towns there are usually more males than females (NSO, 2000). This leaves some rural areas with an excess of females over males.¹⁸⁴ Likoma for example, has only 85.9 men for every 100 females. In the context of HIV/AIDS, the larger number of males (compared to females) in urban areas is of relevance to the issue of sexual health workers (Cf. Mburu, 1992: 413). And the presence of more females in the rural areas (compared to males) is of relevance to the issues of polygamy and extra-marital sex.

Then there was the MCP culture of massive and frequent rallies, Banda's nationwide tours, independence celebrations, Youth Week, Mothers' Day Celebrations, Kamuzu Day and other events.¹⁸⁵ All involved bussing men and women to these venues where 'women were sexually exploited by the MCP men' (Mkamanga, 2000).¹⁸⁶ This is

¹⁸⁴ Largely due to migration in search of employment.

¹⁸⁵ Kamuzu Day originated in a directive by Dr Banda (MCP Circular No. P15/ADC/66, 27/6/63).

¹⁸⁶ MCP officials and the youth leaguers apparently took advantage of rural women who were away from home, sometimes for the first time, but also because they were not adequately fed while on the dancing trips for the party (Mkamanga, 2000).

corroborated by one of my interviewees, Mr Kasusu (Personal communication, Zomba, 26/7/00) who spoke about the changes in sexual mores with the passage of time. He was born in 1949, and lived through the one party era. He blames some of the increase in 'sexual activity' on the various activities that were associated with the Banda regime: Youth Week culture,¹⁸⁷ huge independence celebrations, and the dancing women's trips.¹⁸⁸ He gives an example of the abuse of women by party activists: a businessman detained for opposing the sexual abuse of his 'attractive' wife by a local party chairman. Mr Kasusu feels that the celebratory and dislocated contexts of these occasions contributed to the 'promiscuity' of that time.¹⁸⁹

Then when HIV/AIDS came, in 1985, 'some people refused to believe that it was serious' (Kasusu, personal communication 26/7/00). They thought that it was a manifestation of the diseases caused by transgressing sexual taboos (*kanyela* or *tsempo*).¹⁹⁰

The government was, for a number of reasons, including tourism and Dr Banda's pride, not keen to have Malawi labelled a high HIV incidence country and tried to suppress this information.

From a medical and moral perspective, the Banda government can be faulted for its cynical neglect of duty of care. Even though, by 1994, '20 – 30% of all in-patients had HIV related illnesses' (Lwanda, 1995) the government was still minimising the problem. As Liomba (Wangel, 1995: 26) noted, 'It took the government too long to accept that there was an AIDS problem', leaving the population dependent on inadequate hospital services and traditional practitioners.

Dr Banda's regime was fortunate to benefit from a thriving economy, based on the growth of the tobacco and estate sector, between 1966 and 1979 (Cf. Pryor, 1991; Mhone et al., 1992). When the recession and the IMF's Structural adjustment

¹⁸⁷ This was a weeklong national celebration with dances, exhibitions and the bussing of school children and women from one part of the country to another (See 3.3.4).

¹⁸⁸ President Banda's rallies always featured masses of women praise singers.

¹⁸⁹ Ngulube-Chinoko (1995: 89 – 99) makes a similar point.

¹⁹⁰ 'STDs' caused by infidelity or moral transgression.

programme started to affect Malawi Dr Banda was able to contain deficiencies here by donations from the Western and South African donors through playing his 'Cold War anti-communist' card. But most of this money was ploughed into prestige projects like the Kamuzu Academy and the New State House rather than on health or other sustainable projects. As if to demonstrate the political cynicism, the first substantive AIDS promise from Dr Banda's regime came just before the 1993 referendum (which the donors had helped to impose) on multi-party versus one-party rule.

4.8 The regional context

Three major events best illustrate the state's negligence in relation to HIV/AIDS.

4.8.1 *The war in Mozambique.*

The first was the Malawi Army's involvement in Mozambique between 1985 and 1993 in defence of the Nacala railway line.¹⁹¹ A 500-strength battalion of mostly single men, replaced every six months, was sent to guard the Liwonde to Nacala railway line on its Mozambique section. This was, apart from the counter-insurgency campaigns of 1964 – 1971, (mostly against civilians), the first time that many of the younger Malawian soldiers had been in real combat. As one of them explained

When you went there you did not know if you would come back alive... RENAMO were brutes... (Danganya, personal communication, 22/11/93).

This tension necessitated relaxation. For 'recreation' many frequented the sex workers both in Malawi and Mozambique (Nkosi, 1999). The male/sex ratio factor, exacerbated by the expected high casualties appears to have operated in the army, with 'absent spouses being comforted by other spouses partners' (personal communication, unattributable, July 2000). As in all violent conflicts there were incidents of female

¹⁹¹ After Mozambique became independent of the Portuguese in 1975, right wing insurgency had arisen under the banner of National Resistance Movement of Mozambique (RENAMO). Because Banda was sympathetic to RENAMO and its South African backers, RENAMO used Malawi as a base. Despite the hospitality, RENAMO disrupted Malawi's railways (Hedges, 1989: 617 - 644).

sexual abuse (Cf. Akeroyd, 1997). From 1990, many AIDS deaths occurred in army barracks. The army became seriously debilitated.¹⁹² Yet until 1996, the subject of how the war in Mozambique ‘spread HIV’ remained taboo. Any discussion of HIV in the army was a dangerous subject, liable to elicit a violent reaction from some of the soldiers. When the *Daily Times* published this then obvious fact, in 1996, renegade soldiers from the army threatened to ‘bomb’ the *Daily Times* offices and destroyed some printing machinery.

4.8.2 *The Mozambique Refugees*

Allied to the Malawi army’s involvement in Mozambique was the second influx of Mozambique refugees into Malawi. In 1961 when the Front for the Liberation of Mozambique (FRELIMO) wars were in progress, many refugees had, in the first influx, sought sanctuary in Malawi, returning home briefly after independence from the Portuguese in 1975. The RENAMO/FRELIMO war had subsequently caused a second massive influx of refugees into Malawi border areas. This human influx had caused social, economic, environmental, demographic, and public health problems for Malawi, not least of which was the social interaction between indigenous Malawians and the refugees in the context of HIV spread. The transitional camps were areas where traditional norms had been disrupted. Those with money could buy sexual favours, which those – and there were many among the refugees - without sold. Many of the refugees had suffered from the RENAMO practice of splitting families (Cf. Hedges, 1989). Given that the refugees were located in a belt that extended from the Mchinji/Zambia border, down through Dedza, Ntcheu, Mwanza/Neno, Chikwawa, to Nsanje, and then up through Mulanje, Zomba up to Mangochi, nearly every part of Central and Southern Malawi was affected. Traffic between Mozambique and Nkhata Bay, via Likoma, ensured that the Northern Region was not spared.

I have argued elsewhere (Lwanda, 1993: 167 - 168) that, although the Malawi government got praise for their care of the refugees, this was akin to praising one of the

¹⁹² With British, South African and EEC funding, the army had increased to over 10,000 personnel (Britannica, 1995). In 1984, the Malawi Army had 4,500 soldiers (IISS, 1984). By 1999, the manpower levels had dropped to 5000 (Britannica, 1999).

accused. Malawi, through its active support of the South African backed RENAMO faction was responsible for some of the success of the RENAMO insurgency, as well as its prolongation (Cf. Hedges, 1989). The Malawi Government effectively had its cake and ate it; at once backing destabilisation while being praised and paid for looking after the victims. The concern in this thesis is with the human results of the refugee situation in terms of the increased poverty, the environmental degradation worsening that poverty and the opportunities for HIV spread facilitated by that insurgency to which the Banda government contributed.

From the HIV/AIDS perspective Kamowa (1994) showed that the refugees, as will be shown for my student respondents, were 'fairly' aware of HIV/AIDS but females faced similar disadvantages as their Malawi counterparts.

4.8.3 *The Malawian migrants to South Africa*

Another HIV/AIDS episode, which brought the medico-cultural and socio-economic strands together, was the decision by South Africa, in 1988, to repatriate existing and stop recruiting Malawian migrant workers. *TEBA* (The Employment Bureau of Africa) had been important to the economic life of Malawi. Apartheid South Africa (SA), Malawi's 'friend', liked the non-unionised Malawian workers. Many roadside small traders, shopkeepers, tailors, and bar owners were former migrant workers. Judged by rural standards they had high incomes. Because of their money, they were favoured both by the prostitutes (in South Africa and Malawi) and poor women in Malawi. This made them both vectors and victims of HIV. When HIV-testing of migrant workers in South Africa began in 1985 and 1986, the HIV-positive rate was highest in Malawian workers (Chirwa, 1988) and the South Africans classed Malawi as a high-risk country. By February 1988, the repatriation of Malawian workers began and finished within two years. This hurt Malawi's rural areas economically, highlighting Packard's (1989) analysis, which saw AIDS, like TB, as being facilitated by the poverty, malnutrition and other socio-economic disadvantages related to capitalism. As in colonial times, postcolonial Malawian migrant workers were an economic tool of the state, tolerated in

health, but an embarrassment in adverse circumstances.¹⁹³ Because of the poor and crowded living conditions TB, even before the HIV epidemic intervened, was a major health problem.¹⁹⁴

Incidentally, towards the end of the decade the number of HIV patients presenting with TB in Malawi increased (Kool et al., 1990: 128 – 132; Nyangulu, 1990: 7). By this time, beginning in 1988, 11 district hospitals were able to test for HIV. The exponential rise in TB cases paralleling the rising HIV infection rates has been demonstrated (Harries et al., 1997: 771).

The donors

Donors can be blamed for colluding with the Malawi state. First, foreign NGOs and some donors placed family planning highest on their priorities. Because of this imperative, and second, because of Dr Banda's autocracy, few dared criticise or challenge government policies for fear of jeopardising their limited research projects. The WHO regional and local officers were weak and, as intimidated as local Malawians, deferred to Banda's 'temperament' (Cf. King, 2000: 34 - 35), shelving their concerns in order not to upset the regime. The donors promotion of 'condoms and personal human rights' in a 'communal culture' was sometimes seen as tantamount to counselling free personal sexual choices in the context of a communal culture. This, as King (2000: 34) puts it, if from a different perspective, left people 'free to contract or spread HIV'.

By 1991 the HIV/AIDS health promotion discourse was still palliative. The Catholic Bishops challenge to Banda in 1992 (Lwanda, 1993) cited health as one of the areas of inequality between the rich and poor.¹⁹⁵ Their critique of the Banda regime undermined

¹⁹³ In 1974, a plane crash in Botswana killed 74 Malawian workers. Banda, embarrassed by the international publicity, temporarily stopped TEBA recruitment, citing 'safety'. The recruitment was later quietly resumed.

¹⁹⁴ TB is now recognised as an AIDS associated and defining illness. Incidentally, many of the former migrant workers, because of bureaucracy died before their entitlements to their industrial compensations for contracting TB and other industrial diseases could be settled (Personal observation and conversation with a claimant and relative, June 2001).

¹⁹⁵ This pastoral letter containing grievances about poverty, hunger, repressive governance, poor and iniquitous medical facilities can be, in retrospect, viewed as a culmination of the arguments by NGOs

one of its public health legitimising constructs: a land of 'milk and honey' (*mkaka ndi uchi*) where people were better fed, dressed, educated and lived in 'houses that did not leak when it rained'.¹⁹⁶ AIDS and its sequelae, including worsening poverty and unequal provision of services exposed this myth.

Banda's fall interrupted the Second NAC medium term plan (1993 – 1998).

4.9 The multi-party era (1994 – 2002)

The new administration of President Muluzi, which came to power on the 24th of May 1994, inherited a poor Malawi; where 49% of under five children suffered from stunted growth; 27% of children were underweight; 90% of the population lived in rural areas; 422 students shared each classroom;¹⁹⁷ 80% of rural smallholders existed on less than 241 *kwacha* (per capita); and where children often start work before age of 15 (World Bank, 1995). The under five mortality was 189 deaths per 1000 live births (National Statistical Office, 2000b). This means that almost one in five children born in Malawi failed to celebrate his/her fifth birthday. About one in ten live births failed to reach their first birthday, and then almost one in ten live born children who survived to age one failed to reach age 5. The data indicates that about 40 percent of all infant deaths in Malawi occurred within their first month (neo-natal mortality rate was 42 per 1000 live births) of birth (National Statistical Office, 2000b).

However despite their earlier stance - and manifesto - the United Democratic Front's (UDF) promises did not translate into immediate action. Apart from liberalising research rules, there was insignificant government activity until 1999, when donors provided increased funding. Yet, back in 1994, the UDF manifesto (UDF, 1993: 32) had set AIDS as a high priority.

1. UDF will make health a priority target sub-sector.

and other activists – bolstered by the donors changed priorities after the onset of Michael Gorbachov's *glasnost* – we have noted above (Cf. Lwanda, 1996; Schoffeleers, 1999).

¹⁹⁶ This was one of Banda's oft-repeated sayings (Banda's speeches for the period 1971 – 93, MBC recordings).

¹⁹⁷ Each class was used twice or thrice daily because some schools had two or three streams.

2. Budgetary allocation to the health service will be increased to reach the WHO-recommended per capita allocation...
3. AIDS will receive more attention through health education and counselling... (p 32).¹⁹⁸

It had good reason. By 1995, HIV/AIDS related illnesses accounted for one third of all admissions to hospital (Lwanda, 1995) and the prevalence rate (Kaluwa, et al, 1995) among pregnant women ranged from '5 per cent in rural Thonje to 33 per cent in Blantyre with a median rate of 16 per cent.' For most of 1994 - 1995 there was a shortage of reagents for blood testing (personal observation, 1995). Yet in the first two years of its administration, while emphasising poverty alleviation, apart from one high profile 'HIV awareness walk' by Muluzi, there were no similar high profile HIV public statements.

In an echo of the Banda era of the 80s, the Muluzi administration spent more money on state houses, diplomats, political meetings, international conferences and other presentational events (Chirwa and Kanyongolo, 2000), neglecting health promotion and service provision. As Mburu had noted for Kenya (1992: 418)

The fact that health services are not tangible [sic] also significantly lessens their political visibility.¹⁹⁹

In the meantime, the HIV burden was compounding the rural poverty, leaving traditional practitioners both to cope with the burden of medical care, as well as to formulate their own solutions. In Malawi formal social security and welfare provisions do not exist. Poorer families engage in labour intensive income generating activities to alleviate their poverty. People generally depend on the extended family system as well as friends for support. The many chronically ill people, deaths, funerals and orphans that result from HIV/AIDS all add to the burden on the communal welfare system. This leaves fewer able-bodied people working even harder to support the informal system.

¹⁹⁸ See also personal communications with Mpinganjira, B., Mtafu, G., Muluzi, B., Chibambo, Z., and others in my archives between 8/4/92 and 25/5/94.

¹⁹⁹ With the admission by the British Chancellor, Gordon Brown, in April 2002, that the politically sensitive NHS was under-funded and the debates around health provision in Europe, the USA, and particularly, South Africa, this concept will, in the Malawian context, become untenable.

Because of its 'comprehensiveness' this informal social security system has led to successive colonial and postcolonial governments ignoring or under-prioritising the field of social security. This under-prioritisation is often achieved using the rhetoric of 'tradition and traditional values'. Indeed at some points the Banda and Muluzi administrations diverted social welfare remittances of migrant workers to other sectors.

At the same time, partly due to the uncertainties of the transition, the NAC suffered 'planning and budgetary' problems. By April 1995, 'unpaid', Liomba had resigned and returned to the University. The apathy, seminar culture and 'muddling through' started by MCP continued under the new UDF administration. The new Health Minister, George Mtafu, a neurosurgeon, missed the opportunity to mobilise the youth through schools and the media, as their manifesto had promised. The burden of work on HIV fell on NGOs and mission and state hospitals 'blundered through' with little resources. Kakhongwe (1997) identified 73 international and local organisations dealing with HIV/AIDS, largely funded by Action-AID, the British Overseas Development Agency, the United Nations Development Programme, the United Nations International Children's Education Fund, the United States Agency for International Development, and the World Health Organisation. The Malawi Government's contribution was not quantified. However, as Kondowe et al (1999: 19 - 20) point out, there was lack of coordination, networking and exchange of research information between many of the agencies.

Despite his initial lack of action on HIV/AIDS Muluzi contributed to a resurgence of traditional medicine by maintaining an ambiguous stance similar to Dr Banda's. Muluzi, on becoming president in 1994, also actively personally promoted private western medical provision, claiming that the government could not provide all the services. In this regard he went as far as exhorting clinical officers and doctors to open private clinics.

Further, his administration failed to tighten trading standards legislation, leaving markets full of fake or stolen (from hospitals) unprescribed antibiotics and other western medicines. There was no attempt to regulate the activities of various neo-traditional urban practitioners who were not registered with the Ministry of Health.

Muluzi, between 1994 and 1999, failed to utilise his immense popularity in the HIV/AIDS arena. Interestingly, as had happened with Banda earlier, Muluzi cultivated the cult of the *sing'anga*. In 1995, many debates ensued from the awards of honorary doctorates, beginning with Lincoln University in the USA and culminating in one by Strathclyde University, to Bakili Muluzi, which created the same politically ambiguous appeal of the *sing'anga* (doctor).

4.10 Elite Self-interest

However, as with the colonial and Dr Banda's regimes, it was self-interest that finally roused the Muluzi government from its apathy to the gradual admission that it had a 'national problem'. Between 1994 and 1998 the UDF lost over twenty of its MPs and senior activists, most, allegedly, to HIV/AIDS. As Sam Mpasu, the Malawi Parliament's speaker put it:

Imagine that 29 MPs have died of AIDS-related illnesses between 1994 and 1999. This is very alarming... (Mpasu, 2000).

The government had initially used scarce government money to provide South African treatment for those elites in the upper echelons of the civil service, parastatals and politics.²⁰⁰ But by the middle of 1995, South African clinics had adopted a policy of 'HIV-positive patient repatriation', because few Malawians could afford the anti-retroviral therapy or prolonged hospital treatments. On returning home treatment was provided in private clinics or paying sections of the hospitals at government expense. Although private hospitals did well out of these arrangements their role in HIV/AIDS prevention has been minimal.²⁰¹ Private medical services, in the Malawian context, rarely provide preventive services. The public does not appear to want, and is mostly unable, to buy into preventive services.

²⁰⁰ The Muluzi's goal was mass 'Poverty Alleviation'. But as the political elite were seen to be helping themselves first, wags dubbed the policy 'Personal Poverty Alleviation' (Lwanda, 1996: 227 - 240).

²⁰¹ Private medical services in Malawi, in this context, exclude mission hospitals; which provide services at minimal charges to rural areas. NGO services, which provide free medical care, are also excluded here. Mission hospitals are grouped under (Christian Health Association of Malawi CHAM) to distinguish them from government services. There are a number of small private hospitals – Mumbwe Clinic in Mzuzu; City Centre Clinic and Kawale Clinic in Lilongwe; and Chitawira, Soche and Gombwa Clinics in Blantyre. Malamulo and Mwaiwathu, the largest, are both in Blantyre.

In Malawi, the elite private clinics were also subject to uneven standards and poor regulation. In 1994 – 95, my own observations were that the abuse of injections was just as likely, if not more likely, to occur at some of the private clinics.²⁰²

In 1996 – 1997, two years after Muluzi came to power, *Banja La Mtsogolo* (BLM), the biggest – and one with the greatest rural penetration - family planning NGO, only distributed 612,866 condoms. The fact that Malawi had an adult population of about 4.5 millions at the time demonstrates the deficiency of the ‘condom approach’. (In 2002 it was revealed that PSI had distributed 42 million condoms in Malawi since 1994.²⁰³ This equates to a condom each per year for each Malawian adult). At the end of the decade, the 1999 Sentinel Survey report (NACP, 1999: 21) concluded that the estimated crude national HIV prevalence rate was 8.8 per cent (2.2 per cent among the under 15s, 16.4 per cent among the 15 - 49 age group and 1.1 per cent for those over 50). Among pregnant women rates varied from 2.9 per cent at Kamboni in Kasungu to 35.5 per cent in Mulanje Mission Hospital. In the light of these figures, the Vice President, Justin Malewezi, via his HIV/AIDS Policy Initiative document (1999: 107), admitted ‘Despite the severity of the HIV/AIDS epidemic, the response from [this] Government and the community is not commensurate with the seriousness of the problem’. Malewezi further admitted that, [despite its poverty alleviation programme], the big gap between the rich and the poor with its inbuilt power to abuse the already skewed gender balance was not [being] addressed. Given the post-Banda goodwill the international aid donors had shown to Malawi, a goodwill that had largely been squandered in a new postcolonial cycle of frantic elite ‘self accumulation’, corruption and misuses of government resources (Chirwa and Kanyongolo, 2000) this was an understatement. The resulting initiative towards HIV/AIDS control, in conjunction with the WHO, was elite centred. It involved the reduction of the cost of Combivir (a combination of zidovudine and lamivudine) to K10,000 monthly; making it ‘affordable to high income patients required for Malawi’s manpower needs’ but not the rural or urban poor.

²⁰² The abuse of Rifampicin, an anti-TB antibiotic, was for example a problem at some of the clinics. Rifampicin was often used to treat gonorrhoea.

²⁰³ See <http://allafrica.com/stories/200205080413.html>.

4.11 *Mchape* and the return to traditional therapies

It is not surprising that one of the main events encapsulating the cultural, political and economic aspects of the HIV/AIDS discourse in Malawi was a *Mchape* incident. In 1994, Goodson Chisupe, an ordinary villager claimed to be able to prevent or cure AIDS with an herbal drink (*mchape*) whose formula had been given in a dream.²⁰⁴ People (estimates were of up to 500,000), rich and poor, rural and urban, flocked to his Liwonde village to drink *mchape*. When western white doctors and African medical personnel declared Chisupe a fraud some African medical personnel demanded 'respect for African notions of illness and healing'.

Chisupe's simple action set in motion a series of events which highlighted the desperation and poverty of the sick in Malawi, exposed the shortcomings of the western medical establishment, and showed that many still believed in 'traditional' remedies. It also demonstrated the intimate relationship between governance, culture, legitimacy and communal health. In the rural areas the many 'AIDS funerals' and the care of orphans had led to a resurgence of the 'traditional communal spirit', a spirit at variance with the 'personal poverty alleviation' (Lwanda, 1996) of the elite.

I would see the rise in witch finders of the *mchape* variety like M'bisalira in the 1850s; Kaundula in 1919; Mchape in 1930; Ligomeka in the 1940s; Chikanga in the 1950s; Khwakhwa, Antonyo and Dulawayaya in the 1960s; Simbazako in the 1970s; Naliere in the 1980s, and Mchape in the 1990s, in terms of those transitional phenomena that arise in public spheres at times of transitions, disruptions and uncertainties.²⁰⁵ Crucially these men seek to address 'new threats using old wisdoms'. These are but reconfigurations of age-old witch finding traditions of *mwabvi* (ordeals), which sought to establish the legitimacy of new or contested orders. In the holistic ontological and epistemological contest between western medicine, traditional medicine and real life the *mchapes*, while symbolic, were the marginal, if heraldic, practitioners.

²⁰⁴ In African traditional religion and healing systems messages and medicines are often passed to practitioners via dreams (Cf. Chimombo, 1989).

²⁰⁵ For a detailed discussion of the *mchapes* and other witch-finders, see Chakanza (1985: 227 – 243).

The *mchapes* could also be seen as testing the position of traditional practitioners within the legal framework of Malawi. The Medical Practitioners and Dentists Act (1987) does not prohibit the practice of ‘any African system of medicine’ provided the practice is safe. The *mchapes* attract the gaze of the state but are not the only ones filling a massive unmet need. Malawi has thousands of registered and unregistered practitioners (Msonthi, 1984).

The Malawi Vision 2020 Project (Ng’ombe and Mawaya, 1997: 36) suggestion, that traditional practitioners be more involved and integrated into the health care system to improve rural health care, a call previously heard (Msonthi, 1982; Msukwa 1981), has not yet been acted upon. As noted, until 1981, the weak health campaigns had concentrated on eradicating ‘poverty, ignorance and disease’, without an epistemological exposition of this slogan and without a formal trans-cultural health policy being formulated. It is not surprising that, as Maluwa-Banda (2000) shows, secondary students while having ‘adequate knowledge about the basic facts about AIDS, the transmission of HIV and how they can protect themselves from being infected, ‘still harbour some ‘misconceptions‘. As we have already noted, and will examine in more detail in Chapter Five and Six, many schools are ‘village culture based’, and these misconceptions may reflect attitudes carried over from socialisation in village schools.

Some of the factors we have mentioned above, including elite self-interest, the *mchape* episode and its sequelae, the Vision 2020 consultation process, and the obvious loss of critical infrastructural manpower prompted the Malawi government to formulate a National Aids Strategic Framework. As the NASF is the Malawi Government’s main anti-HIV/AIDS tool, represents authoritative opinion and is the basis of most future government and NGO policies to HIV/AIDS, it is appropriate, for the purposes of this work, to examine this framework here.

4.12 A critique of the Malawi National Aids Control Programme (NACP) National Aids Strategic Framework (NASF) 2000 – 2004.

This work, which was started in 1998, under the coordination of a core team from the National Aids Control Programme included input from unspecified “non-governmental, religious and community based organizations and traditional institutions”. The Vice President, Justin Malewezi and the Ministers of Health provided the political input and overall control.²⁰⁶ The United Nations Development Programme (UNDP), the European Union (EU), the United States Agency for International Development (USAID) and the United Nations Children’s Educational Fund (UNICEF) provided most of the funding for the project. The dependency of Malawi’s Ministry of Health on initiatives in this sector thus continues.

In the foreword, President Muluzi admits that ‘between 1985 [and 1998], HIV/AIDS prevention and care planning has been guided by medium term plans focusing almost exclusively on bio-medical components of the epidemic’. The social, economic, cultural and political factors determining the course and impact of the epidemic had hitherto been unaddressed’ (sic) (NASF, 2000, foreword).

And according to the Vice President, Justin Malewezi, the NASF hopes to

capture the multi-sectoral and multi-disciplinary nature of the HIV/AIDS epidemic and tackle both the bio-medical and the social, cultural, economic and political factors which together determine its course and impact. The aim is to engender ‘capacity building for increased understanding and analysis of issues; effective utilization of existing socio-economic capital; mobilization and utilization of locally available resources; broad based stakeholder and community participation; and ongoing social mobilization of individuals, families, communities and institutions for collective responses to the challenges HIV/AIDS poses. (NASF, 2000: Preface).

These aims and objectives were to be addressed partly by ‘identifying gaps in the

²⁰⁶ As chair of the Cabinet Committee on HIV/AIDS prevention.

current response and [directing] interventions to issues and dimensions of the epidemic which the [current] responses do not address adequately'. These laudable aims can only be partially fulfilled by the document's strategies. The overall tone of the document is aspirational, not least because the financing of the strategy is 95% dependent on external agencies (NASF 14.7.1). The Health Minister, Aleke Banda (Personal communication, 17/7/01) confirmed that without donor funding the 'NASF is greatly handicapped'. There is a degree of contradiction here in an NASF that seeks to 'mobilize local resources' and which is supposed to take cognizance of local socio-economic factors and yet is 95% donor dependent. The implication is that without external funding the framework may fail. Even allowing for the fact that this may be a kite flying exercise to garner external funding, this emphasis gives signals suggesting a 'donor dependency syndrome'.²⁰⁷

The first section of the NASF is well researched and observed. It begins by outlining the global and local context of the Malawi HIV/AIDS problem, pointing out that the spread of HIV in Malawi is largely via heterosexual sex (NASF 2.1.1 to 2.1.5). Then key estimates of the HIV infection rates in Malawi are given (NASF 2.2.1). The document then notes and recognizes that research shows that 'HIV [spreads] more rapidly in societies and communities which have the following characteristics':

- Societies with wide economic and social stratification.
- Where women are powerless and occupy a low status in society.
- Where social support systems are inequitable and sometimes oppressive
- Where local norms and values condone and encourage extensive sexual networking.
- Where unemployment rates are high.
- Where there are 'flourishing local markets with extensive informal trading networks', and
- Where 'strong social sanctions exist for transgression of cultural, social and religious norms, but where transgressions occur nonetheless' (NASF 2.2.3).

It is, for the purposes of this thesis, noted here and significantly by the NASF itself that all these factors apply to Malawi (World Bank, 1995; UNIMA, SARDC, 1997).

²⁰⁷ This term is used as in 'developing countries that show excessive dependency on external donors' for, not only funding, but sometimes initiating, development projects.

The NSF then goes on to summarise the likely impact of HIV/AIDS on Malawi, noting that annual adult AIDS cases are expected to peak at ‘about 70,000 cases’ in the 2000 – 2009 decade, while annual AIDS cases in ‘children are expected to rise to about 25,000’. The HIV related increase in TB infections is also noted. Perhaps the most telling observation is that the average life expectancy in Malawi which was 45.2 years in 1985, and was expected ‘to rise to 57.4 years in 2010’ is now ‘projected at a low of 44.1 years by the year 2010, representing a 13 year drop’. The burden on the work environment via absenteeism, funeral costs, medical bills, insurance costs is noted, as is the fact that ‘the most productive people in agriculture, secondary and tertiary industries, government and private organizations, are dying disproportionately of AIDS. [These projections predict] that a minimum of 25% and as much as 50% of people currently employed in the urban based sectors would have died of AIDS by the year 2005’ (NASF 2.2.5 – 2.2.11). Significantly, from our educational perspective, the fall in life expectancy, is relevant to the ‘teachers seeing their students’ students dying’ before fulfilling their national duty, a phenomenon that challenges the developmental progress through education concept.

Interestingly, it is noted that ‘the extent of the impact of HIV’ will ‘also be a function of existing socio-economic structures’ and that ‘where dysfunctionality exists, it will become worse as the epidemic deepens’ (2.2.12). Yet, in the solutions, the socio-economic solutions are aspirational rather than realistic. ‘Religious organizations, NGOs, youth groups, lending institutions, business training institutions’, the government ‘public sector community programmes, district assemblies’ and other unspecified ‘training institutions’ are given responsibility for a socio-economic transformation (NSF Annex, 1.7). Given the failure of the same organizations to significantly alter the socio-economic status of rural Malawians over the last 100 years (Cf. World Bank, 1995, Ng’ombe and Mawaya, 1997) this is an aspirational concept. The NSAF, as would be expected of a government document has no solutions for the political dysfunctionality affecting postcolonial governance in Malawi, whether elite domination, corruption or gerontocracy.²⁰⁸

²⁰⁸ Gerontocracy in the Malawian context would have to be re-defined, given the average life expectancy of about 40 years, in terms of the domination of politics by those above the retiring age of 50 (Cf. the Youth Party discourse (Chapter One, page 26 footnotes) and the concept of *mdala* (Chapter

Given its dependency on external funding, the NASF is on stronger, but contestable, ground when it declares (NASF 2.2.14) that ‘our strongest weapon is behavioral change’ (NSF 2.214). This work will show that, in the context of HIV/AIDS in Malawi, behavior change may be, to a degree, a factor of socio-economic circumstances. Because cultural factors are acknowledged but not sufficiently analysed and strategised in the action section of the NASF the ‘strongest weapon’ becomes an aspirational tool.

The framework, it is reported (NSF 1.3.1), is based on approaches ‘adopted in other African countries in the region such as Zimbabwe, Tanzania and Kenya, guided by UNDP, the Joint United Nations AIDS Programme (UNAIDS), and other partner agencies’. Uganda, which is cited as the ‘best example of communal HIV/AIDS prevention in Central and Southern Africa’, is not mentioned.²⁰⁹

The objective of the formulation phase was to reach a consensus on the guiding principles and the approach to be adopted by the NASF, the latter’s objective being to strengthen individual and communal capacity, understanding and ability to respond to HIV’s personal, social and national development impact. This understanding and ability was to lead to effective action. An examination of the methodology shows that it had several levels: beginning in February – September 1998, with first, community focus groups; then proceeding through second, identification of issues and responses in the community; third, rising to the national forum via facilitators; and fourth, at later stages, October 1998 – April 1999, the ‘data obtained from the community discussions and institutional consultations [being] merged’ during the final stages. The final stages, in May – August 1999, were conducted at six regional and sub-regional workshops and then, finally at a national workshop ‘comprising members of the Strategy Planning Unit (SPU) and facilitators of the regional workshops (NASF 1.4.8). The formulation process thus proceeded from the grassroots upwards. The final product, in its

Five) in this thesis).

²⁰⁹ See, for example, the Centre for AIDS Prevention Studies, *JAMA HIV/AIDS*, December 1998 at <http://www.ama-assn.org/special/hiv/preventn/prevent1.htm>. Uganda is viewed as having succeeded better than other African countries because of its grass roots based community schemes and the fact that its activists and community leaders faced up to the reality of HIV/AIDS much earlier than other countries. Philly Lutaya, a popular Ugandan singer was one of the first African superstars to admit having AIDS.

aspirations and conclusions, mirrors this bottom up progression, with a dilution of realism as the work progresses upwards and becomes more subject to the imperative to produce a document that fits in with donor methodology and expectations.

The summary goal of the NASF was of reducing the incidence of HIV and other sexually transmitted diseases. This was to be done utilising the guiding principles of community involvement (stake holding), a legal framework to protect individuals and children whether HIV positive or not, provision of civic education, appropriate child rearing activities, and other measures designed to create a

conducive environment for effective mobilization and utilization of resources, for partnerships to form and for change to occur in those behaviours, values, beliefs and norms which put Malawians at risk of HIV infection (NASF 3.3).

There is no current evidence that the political will exists to enact these legal frameworks. The Malawi legislative and judicial systems have, between 1997 and 2002, been too obsessed with politically inspired amendments to the constitution and ‘politically significant’ trials to cope with issues of HIV/AIDS related human rights issues. There are, for example, in the case of women’s rights and civil rights issues in general (as the HIV/AIDS battles between the South African government and activists shows) inherent contradictions between the motives of governance and the expectations and rights of the citizens.

The specifics of the framework on HIV and, respectively, culture (NASF 3.4.1), youth, and social change (NASF 3.4.2), socio-economic improvements (NASF 3.4.3), despair and hopelessness (3.4.4), HIV/AIDS management (3.4.5), and orphans, widows and widowers (3.4.6) could also be summed as aspirational. In the case of culture it was stated ‘To bring about socio-economic changes that will help reduce the spread of HIV/AIDS... (3.4.1)’. While the NASF (4.1) recognizes that ‘culture forms the bedrock of numerous norms, values, beliefs, and practices which inform views about sex and sexuality and gender relations’ and the need to analyse ‘those cultural values that promote casual sex’ and reform these, the suggested solutions are rather contradictory. The NASF solutions range from the ‘reform of those cultural norms, values and

practices' which promote HIV/AIDS, the review of initiation rites' curricula, the promotion and strengthening of cultural values, beliefs and practices that prevent the spread of HIV and mitigate the impact of HIV/AIDS, orienting traditional leaders to gender issues and human rights, to 'adapting the socialization process of men, women, boys and girls'. Some of these suggested solutions and strategies appear contradictory. It is difficult to change a culture without an associated significant change in that culture's socio-economic context. It is also difficult to institute cultural changes without political will. It is difficult to choose and impose changes to cultural practices without consultation with the traditional male and female cultural power brokers and providing the means to make the change sustainable. The experience during the initiative to bring *azamba* (traditional birth attendants) closer to western obstetric models of the MOH, in terms of training and equipping, shows that enormous resources are required (Ministry Of Health/UNICEF, 1991b: 1; Thom, 1999: i – ii). This would be similar for *anankungwi* (initiation rite process guardians and practitioners). And the NASF's solution to 'despair and hopelessness' was a religious aspiration to 'bring about hope, faith and a spirit of acceptance of the reality of the HIV/AIDS epidemic among all Malawians in order to facilitate prevention and the mitigation of its impact' (3.4.4). It could be said therefore that the NASF is revisiting some of the ideas seen in colonial times, ideas which suggest that it is possible to westernize, in the religious, cultural and social manner, without changing the socio-economic substrate.

Following on from this, the strategy for social change among youth 'to revive the authority of the family, school and religious institutions in the socialization and guidance of young people' by strengthening extended family ties and the traditional roles of uncles and aunts in moral training of [youth] on issues of sexuality, marriage and family' (NASF 5.5.1) and authority figures appears to promote a return to what has been termed "stronger traditional values". This suggestion is bolstered by the suggestion of 'effective regulation to 'protect these young minds' against the 'positive and negative' influence of the media. These strategies would subject the youth to more authoritarian cultural modes that may paradoxically strengthen those cultural practices promotive of HIV/AIDS. These stronger traditional roles without resources and alternatives are reminiscent of the 1980s when Dr Banda's government was in

power.²¹⁰ Further these suggestions for HIV prevention, combined with the promotion of voluntary counseling (3.4.9) in the context of inadequate resources, raises issues of raising expectations against a background of unmet need.

The strategies for addressing gender relations by education, promoting skills development, improved awareness and legislation, promoting equal access are aspirational and long term in implementability. Indeed, neither postcolonial government has, despite the rhetoric, shown any desire to legislate on gender and equality issues. Indeed the intention to strengthen 'traditional values' may disadvantage females.

The weakest section is that on HIV/AIDS management. The proposals (NASF 8.5.1 – 8.5.5) are entirely aspirational in the absence of donor money and government will to prioritise funding, against for example that spent on politics and governance, for health and social sectors (Cf. Chirwa and Kanyongolo, 2000).

The section on orphans, widows and widowers (NASF 9.1 – 9.5) is perhaps the most robust and easiest to implement. All that is missing here is the political will to enact and implement legislation in favour of orphans, widows and widowers and to ensure that the Administrator General's office functions without favour, corruption and delays (M'goola, personal communication, 2001).

It is difficult to argue with the strategy's recognition that 'abstinence and faithfulness are major keys to HIV prevention' and 'condom use is at present the best alternative for safe sex' (NASF 10.1). Of the suggested strategies of 'promoting abstinence and mutual faithfulness', 'encouraging safe sex practices', improving management of sexually transmitted diseases', 'reducing mother-to-child transmission' and 'promoting safe blood supply', only the first two are currently, in terms of resources, attainable. Here the NASF has failed to go beyond the aspirational in suggesting strategies to implement this. The 'distribution of condoms' ignores the rural issues of transport, storage, and cost.

²¹⁰ This is covered in Chapter Three.

NASF strategies for information, education and communication (NASF 11.1 – 11.5), significantly, the most donor funded sector so far, cannot be faulted.²¹¹ The NASF and its predecessors have produced extremely high levels (over 90% in many samples) of awareness among Malawians of all age groups (NASF 11.2). There is recognition that to succeed the framework must build the ‘capacity of traditional leaders and other custodians of culture to utilize effectively traditional channels of communication for HIV/AIDS education’. And also that it should strengthen the capacity of media personnel to develop and disseminate HIV/AIDS messages and materials, which are well targeted and focused. In this section, for the first time, the phrase ‘custodians of culture’ is used. Custodians of culture are not necessarily the *eni dziko* (the owners of the village/land); this power may reside in *asing’anga* (medical practitioners) or *anankungwi* (rites of passage guardians and practitioners). Apart from the aspirational nature of the strategy due to resource scarcity, the section on voluntary HIV testing cannot be faulted. However, the dependency of even this part of the strategy on foreign NGOs is a cause for concern. After all, the institutional funding for the NASF implementation is under the office of the President, as are the technical and political ‘support’. Of particular concern here are the recommendations for ‘main areas of support’ with funding proceeding, presumably from the central government or donors, to community based organizations (CBOs) via financial grants. This is clearly not a universal project as only those CBOs capable of grant application will qualify, leaving some areas and sectors uncovered.

In the context of this study, it is further noted that the strategy offers continued support to the ‘traditional medical’ approach – in this case western orthodox medicine (NASF 14.3). Traditional medicine, the *sin’ganga* variety, is not mentioned. Of the external funds already sourced (NASF 14.4) most is committed to urban projects to provide safe blood transfusions and condom supplies. No specific initiatives for rural areas were noted.

In the Agenda for action (NASF Annex 1) it is also noted that there are inadequate strategies for dealing effectively with cultural values, beliefs, and practices that

²¹¹ Significantly, the most donor funded sector so far.

predispose men and women, boys and girls to HIV infection. And neither are there specific strategies to strengthen cultural values, beliefs, and practices that 'prevent' HIV spread. (Annex 1 and 2). The proposed NASF objective of communities developing 'the capacity to eliminate or reform cultural values, beliefs and practices that facilitate the spread of HIV' is in line with the aims of this study. However, I take the view that the NASF is rather constrained and adopts an approach appropriate to urban, socio-economically better off and westernized dwellers in its approach to culture, prevention and some of the suggested strategies. The NASF is, as it were, predicated on a significant socio-economic change occurring, rather than on the socio-economic realities that are likely to prevail.

Apart from the lack of funding, one of the problems that the NASF, which was finally launched on October 29, 1999, must tackle is the poor networking among organizations that deal with HIV/AIDS, even among academic researchers. For example, a research project, associated with the NASF, on culture conducted in 1999 observed that:

...there are many organisations involved in activities geared towards minimizing the spread of HIV/AIDS in Malawi. The study has also revealed that a number of research studies have been undertaken and have proposed some strategies for combating the epidemic. However, it has been revealed from the study that most of the research findings are not used by organisations and institutions working in the HIV/AIDS area because of lack of accessibility to those studies when conducted by different organisations. About nine-tenths of the institutions [...] surveyed indicated that they are not aware of any research is being carried out (Kondowe et al, 1999: 7).

This lack of net working, often manifesting as endless re-inventions of the wheel, may be a part of the 'HIV/AIDS industry'.²¹² The NASF should have contained a section that creates a mechanism for the efficient use of donor or government resources in the HIV/AIDS sector, to minimise the elite diversion of donor funds.

With specific reference to culture, the authors, significantly, note:

Research studies have also revealed that while some cultural factors

²¹² The proliferation of (useful or otherwise) NGOs because of the availability of donor funding.

concerning HIV/AIDS vary depending on the group, a good number of them are similar. Most of the institutions surveyed recognise [the importance of culture in the fight against HIV/AIDS]... [But due to lack of net working] most of the activities undertaken by institutions to address cultural aspects are not based on research findings in this area as there is no link between research work and activities in which institutions are involved (Kondowe et al, 1999: 7).

These authors also suggest, rightly, that self-interest may affect institutional policies

Some institutions have implementation requirements/procedures and policies that do not have the flexibility to take into account cultural issues, particularly the positive ones e.g. abstinence, which they think, would negatively affect their primary objectives. Examples of such institutions include those that are involved in selling contraceptives and condoms (1999: 7).

The problems of involving the rural areas were recognised:

Most of the institutions involved the Communities in dealing with cultural aspects of HIV/AIDS. In such activities the community leaders have been seen to play a crucial role in influencing their subjects to accept messages on HIV/AIDS. Some organisations working in the media have faced problems in their campaign against HIV/AIDS in rural areas because of limited access to newspapers and the radio and due to high illiteracy levels. They have utilised aspects of culture such as traditional dances and village cultural festivals to transmit messages on HIV/AIDS (ibid).

As already stated, levels of awareness about HIV/AIDS issues are up to 90%, even in some rural areas (NASF, 2000).

In the final analysis, the NASF can be faulted for being too dependent on external funding, too aspirational in design and nature and in not paying more attention to the socio-economic prevailing realities in Malawi. The dangers of this dependency are highlighted by the fact that Denmark, one of the major donors to the NGO sector, withdrew its aid in February 2002.

As the study focuses on school students, the next section (4.13) deals with theoretical issues pertaining to education and culture. Section 4.13 attempts to contextualise

educational and cultural issues within the wider concerns of the study, the dynamic between inadequate educational resources, a strong indigenous culture and the state's desire for education to play a progressive modernising and developmental role.

4.13 Theoretical issues pertaining to education and culture in the Malawian context.

We have examined the history of HIV/AIDS in Malawi and identified how factors like politics, culture and the dual medical system shaped the epidemic itself and the responses to it and, consequently, its magnitude. The limited dialogue between traditional and western medicine, despite the former's major service provision role, has been highlighted. In this section, we pursue this theme of lack of a resonant engagement between localised traditions and western concepts, in this case, western or formal education.

Methodology

The present section is constructed from literature reviews and my own fieldwork.

To illustrate the wider socio-cultural context within which western or formal education operates in Malawi a number of markers such as *ufiti* (witchcraft), poverty, class, wealth, issues of governance, *kukhwima* (fortification), heterosexual relations, family planning, traditional practitioners, the role of women, specific traditional practices, attitudes to condoms, some issues of socialisation, the persistence of the *mdulo* (sexual avoidance taboos) concept and other traditional cultural markers like scarification, are utilised to construct a framework of prevailing cultural attitudes.

Theoretical issues pertaining to education and culture in the Malawian context.

Here I concentrate on the role of culture, particularly on its dynamic with the educational and socialising process, in order to further demonstrate why, given the socio-economic context, culture was, and continues to be a critical factor in shaping the

form and magnitude of the HIV/AIDS epidemic even among school students. Here we also seek to identify the wider socio-cultural contexts in which school-going Malawians hear about, develop attitudes to, encounter, experience, and respond to HIV/AIDS.

Malawi's many ethnic groups show similarities and differences in their localised traditions (Cf. Msiska, 1995; Breugel, 2001; Rangeley, 2000). Here it is argued that, as others have suggested (Tembo et al, 1993; Kamwendo et al, 1999), these different localised traditions ultimately, in their different ways, collectively affect attitudes to HIV/AIDS.

In contrast to some earlier observers, it is argued that cultural practices cannot be changed by education alone. While differences between ethnic groups are often problematic, in the school contexts the similarities in many of the cultural practices and beliefs facilitate students peer socialisation. This peer socialisation may continue in work and residential environs depending on socio-economic factors. And due to this institutional and mutual peer multi-cultural socialisation those attending school, despite not necessarily abandoning some of the beliefs associated with their own ethnic groups,²¹³ may show more similarities in outlook to specific issues like HIV/AIDS with youths from different ethnic groups (Cf. Kishindo, 1998; Chilimampungu, 1998). The school contexts, particularly boarding schools, have been noted to be particularly good sites of peer socialisation (Chimbwete, 2001: 43). This process of peer socialisation, an element of hybridisation (Cf. Werbner, P. et al., 1997) is a function of the interaction of Christian, Muslim, Western, and the multi-ethnic indigenous traditions becoming syncretised into a youth culture, within and without school contexts. It is a process that has been seen in other African contexts. In Soweto, the creation of *kwaito*, a new form of music is testimony to 'the agency of young black people and the ways in which they humanise, narrate and critique the harsh and hostile urban environments in which they find themselves' (Peterson, 2001). The relevant point here is the failure of the educational and socio-economic systems to provide a more significant socialising role.

²¹³ Such as *chokoro* (widow inheritance) among the Tumbuka and cultural beliefs arising from *jando* (initiation) rites among Yao males. Circumcised Yao students, for example, looked down on the uncircumcised.

However, in Malawi, because of the strong rural cultural traditions, holiday periods and the economic contributions made by parents, the influence of rural norms is continuous and dominant. The schools, therefore, can be homogenizing agencies without necessarily satisfactorily fulfilling the modernising, developmental, or health promotion roles.²¹⁴

In the decade of Mbeki's revival of the 'African renaissance' concept,²¹⁵ when developmental knowledge is intended to liberate Africa from its current poverty, and other problems, it is necessary to examine the socio-economic context (Cf. Barber, 2001: 181 – 182).²¹⁶ The site of initial dissemination of this developmental knowledge is intended to be the primary school (Cf. Malawi MOESC, 1992). But, given the pyramidal nature of the educational system in Malawi, the primary school ends up being, for the majority, their only educational experience (World Bank, 1995: 10 – 17). We argue that the failure of the schools to adequately achieve this modernising task is facilitated by the gap between imparted knowledge and the socio-economic realities of the Malawian context.

The Malawi School syllabus has a social studies curriculum that attempts to promote the acquisition of

citizen skills... ethical and socio-cultural skills... economic development and environmental management skills... occupational and entrepreneurial skills ... practical skills, and scientific and technological development skills (Malawi MOESC, 1998b: iii).

The limiting factors to achieving all of this clearly include culture and resources. Resource allocation, as we have already seen, did not usually favour health or universal education in the Banda era (World Bank, 1995:10). Towards the end of Dr Banda's era, the primary (Malawi MOESC, 1992) and secondary school syllabi were both

²¹⁴ This process of hybridisation, in the sense of a mixing of cultural imprinting during socialisation, has, in the Malawian context, to be seen against the issues of globalisation, transient urbanity in secondary and university colleges and the rural nature of most of Malawi. In the context of HIV/AIDS it is the periods of exposure to sexual practices and the influences acting at those points that are critical.

²¹⁵ Now 'incorporated' into NEPAD (New Partnership for African Development).

²¹⁶ Barber's is a critical discussion of cultural change in South Africa since 1994. President Mbeki has adopted an ambiguous approach to the subject of HIV/AIDS. At times he has rejected the causality link between HIV and AIDS (see for example *New Africa*, June 2001: 18 – 24).

specifically reviewed, again with no obvious revision of resource allocations, in the light of

emerging issues such as overpopulation, gender, environmental degradation, HIV/AIDS related diseases and civics education ... (Malawi MOESC, 1998b: i).

While the secondary syllabus is more specific on social issues, the primary syllabus also includes teaching on social issues and HIV/AIDS. Significantly, both primary and secondary school social studies curricula address the issues of 'ill health, drug and alcohol substance abuse, HIV/AIDS and sexually transmitted diseases, crime and breakdown of law and order' (Malawi MOESC, 1998b: xi and 21), from a moral perspective, under the theme 'the effects of breakdown of moral values'. This theme of social and moral values also includes topics on:

human virtues and vices (justice, courage, humility, prudence, charity, self control, tolerance and their opposites)... adolescence and social environment (personal, physical, sexual and psychological development, friendships, relationships with peers and parents, sound decision making)... good health habits; responsible adolescence and interpersonal relationships, keeping out epidemic diseases... control of one's sexual emotions... observance of norms and values of society... (Malawi MOESC, 1998b: 23 - 29).

It also has a high moral aspiration quotient, reflective, as we note later, of the dominant abstentionist attitudes in the government's HIV prevention programme. In sum, this agenda has elements that attempt to educate and modernise. These could, at one level, be regarded as designed to 'westernise', in the broad and progressive sense of the word, making them aware of and able to survive in a modern, global world.

In Malawi, competition is intense at all levels of school selection. From the beginning therefore, this agenda is subverted by this intense race for the top of the schooling pyramid, a race synonymous with jobs, western life-styles and an escape from poverty. Schooling becomes essentially a tool for passing examinations. This modernist syllabus agenda also, because of its high moral tone, has no apparent conflict with the positive aspects of indigenous culture. However the inclusion of the undefined 'norms and

values of society' and the moral aspects are, in the context of a multi-cultural and multi-faith society confounding and potentially contradictory factors. In contexts where the necessary socio-economic resources required to bring elements of modernity are lacking these confounding and contradictory factors promote ambiguity and identity crises (Cf. King et al., 2001).

In this regard, President Bakili Muluzi's universal free primary education, introduced in 1994, has not reversed the rich/poor disparity in education (World Bank, 1995: 17). The pyramidal educational structure persists, compounded by class disparities. In 1994/5, the richest population quintile received 16% of primary, 39% of secondary, and 58% of government education funds, while the poorest quintile received 19%, 09% and 01% of government educational funds respectively (World Bank, 1995: 16 – 17). If the developmentalist strategy is to have a working chance more spending among the poor who cannot afford private education will be essential.

Interestingly and resonating with the argument in Chapter Two, HIV/AIDS is seen as one of the 'problems caused by irresponsible adolescence (Malawi MOESC, 1998b: 29)' and 'the effects of breakdown of moral values' (p 57). In this regard the school syllabus complements the traditional strict norms because deviation from the norm is regarded as breaking moral values (Cf. *mdulo* in section 5.4.1.2). The schools, both primary and secondary, are critical sites for the dissemination of attributes intended to deliver healthy individuals, in the modern sense, individuals who will maintain communal order. However without a critical epistemological differentiation of the contradictions between the social norms intended by the syllabus and those intended by traditional order, the first and perhaps most critical site of dissemination of this developmental knowledge - the primary school - will probably, in the short term, be unable to appropriately fulfil, if not articulate, this role. King noted in 1987 (p 524):

Schools – especially primary schools – seemed to be becoming more dependent on the village and the local community than upon the government, for their construction, repair, and the material needs. In many areas they had large cadres of untrained teachers, and few contacts with the government apparatus for advice, in-service and inspection. Yet they were being asked to deliver a complex agenda of literacy, numeracy and a whole new menu of developmental knowledge.

Because Malawi primary schools are under-resourced, it is more accurate to say that the average primary school is more dependent on village resources than that the primary school contributes in material terms to the village²¹⁷. The introduction of free universal education has spread even more thinly previously thin resources. The majority of teachers are not fully trained, HIV/AIDS has taken many of the trained teachers and the state does not provide sufficient funding (Cf. Munthali, 2000: 152 - 165). It was disclosed by the Ministry of Education, in January 2002, that Malawi was losing about six to eight per cent of its 60,000-strong teacher work force to HIV/AIDS annually (Matebule, 2002).

In Malawi the primary school serves a number of functions: producing literacy for a proportion of children of school going age, nurturing and delivering to secondary schools a tiny proportion of its students, and acting as a meeting place between village culture and aspects of modern culture.²¹⁸ The fulfilment of these functions is subverted by financial and manpower constraints. The current Malawi primary school should generally, therefore, be seen as a dependent variable in the relationship between it and the village. Because of the larger input of resources from its local surroundings, the cultural knowledge being disseminated at this level will inevitably depend on the cultural attitudes and beliefs of the teachers and the village elders facilitating its subsistence. Therefore the attributes conveyed by these inadequately staffed and poorly funded schools may, by default through resource and teaching staff deficiencies, end up being significantly those of traditional village culture.

From this study's point of view, that would not of itself be a problem if, first, all of these values were helpful in containing the HIV/AIDS; second, they were generally such that they enabled the students to cope with the dual medical systems; third, they did not impede those students able to benefit from the limited educational system; and finally if they were compatible with a developmentalist outlook.

²¹⁷ For example, the annual public education spending for each student in 1994/1995 was K220 (£55) and the Students/permanent classroom ratio was 422 (schools are taken in two shifts per day; one group starts at 7 am and the next at mid-day). Further there was a considerable bias against primary school students, in terms of annual financial spending, as compared to secondary (1:7) and university (1:97) students (See World Bank, 1995: 10 – 17).

²¹⁸ Primary schools, for example, arguably provide most rural areas with postal addresses.

Given the similarly crudely pyramidal and competitive nature of secondary education, the same case is made here for the secondary schools, which are particularly short of trained teachers. Secondary education follows, in an even more acute form, the intense competition seen in senior primary school with respect to the need to pass examinations. Given the constraints of space, it is not really necessary to repeat the arguments here for secondary schools. Suffice to note that there has been, reflecting an unmet need and this competition, an explosion of private secondary schools, many little more than an individual's compound. The standards vary from mostly dire to half a dozen or so excellent ones.

Examining the Primary School syllabus shows the importance of trained teachers. The developmental knowledge meant to be imparted to primary school children according to the New Primary School Syllabus, involves:

Thirteen subject areas... Seven subjects (primary mathematics, music, physical education, religious education, creative arts and languages) will be offered throughout the course. General studies will be taught from Standard 1-4 and will continue in Standards 5-8 as Social Studies. Agriculture, home economics, science/health start at Standard 5, while needlecraft will start at Standard 3...

General Studies and Social Studies are newly constructed subjects. These are integrated subjects made up of elements of science, health, agriculture, geography, history and civics. This structure is based on the theory that during the formative years children should perceive the world as a unit, but should understand it as an inter-relationship and/or an inter-dependence of phenomena, matter and events of which they are part ... the social studies course shows concern with four main areas, namely... a) physical environment, ... b) social structure of Malawi society and its cultural values... c) survival skills for independence and contribution to society, and d) an understanding of the micro-environment in the context of the macro-environment (Hauya, 1993: 42).

This syllabus is obviously intended to deliver a developmental knowledge as well as enabling students to simply pass examinations. Untrained teachers may fail to fulfil both requirements. Untrained and poorly trained teachers, may, apart from struggling to teach these subjects adequately, also be inappropriate role models for the students. Drafting in secondary school dropouts and people who have failed to obtain their first job choices may not produce the most suitable 'untrained' teachers. Further these

primary school teachers, especially after the introduction of free primary education, frequently worked in isolation from district and regional supervision.²¹⁹ The Ministry of Education Sports and Culture (Malawi MOESC 1998a: 36) admits to this in its own analysis. The World Bank has put this in even more strong terms

Thus children in Malawi attend schools in which the most basic pre-conditions for creating a positive learning environment are missing (World Bank, 1995: 17).

This sentence, written just after the introduction of universal free education for all in 1994, applies even more today; Malawi has lost more teachers and, as already noted, has less donor support. The 2001 – 2002 famine has strained village resources.²²⁰ Therefore the paradox of a dependent institution (the primary school) changing the culture on which it is dependent (the village) through developmental knowledge is currently unlikely to be realised in many areas of Malawi.

In this Chapter, however, with reference to HIV/AIDS, it will be demonstrated that, whatever the shortcomings of the school system, some theoretical knowledge about HIV/AIDS is, because of the syllabus, social impact of HIV, and the teaching models, imparted to and retained by students. The problem (Cf. McAuliffe, 1994) is that even armed with this knowledge, the subsequent behaviour of school going Malawians, once sexually active, has owed more to cultural factors and socialisation than to this school derived theoretical knowledge about HIV/AIDS. As Chimbwete observes

This study also highlighted the incapability of young people to take precautionary measures against HIV in a sexual relationship even though they know what to do (Chimbwete, 2001: 274).

It is the intention of this study to demonstrate that socio-economic factors also influence these behaviour patterns.

²¹⁹ Personal communication Lwanda, M. L. C. (22/7/01).

²²⁰ In selling off the strategic maize reserve, via companies controlled by *achikulire* (elite) entrepreneurs, in June 2001, the government left rural ADMARC depots with maize stocks which the elite could sell to villagers at high prices (Cf. Gunya, 2002; and <http://www.allafrica.com> records of February to March 2002). Later allegations, including those of donors, blame Dr Muluzi's regime for economic mismanagement, government overspending and 'Third termism' for worsening rural poverty (Cf. *Scotland on Sunday*, April 28, 2002; *BBC News Africa*, 14/5/2002; *Johannesburg Star*, 31/5/2002).

We thus note that although the syllabus has an honourable and progressive agenda, its motives and implementation are subverted by lack of resources. The educational system in Malawi effectively is a pyramidal process of producing elites, with a large number of students dropping out at primary and secondary levels (World Bank, 1995: 10 – 17).²²¹ The modernisation and westernisation agenda cannot be, in the majority of cases, fulfilled. In effect the colonial model of education and outcomes persists, if we ignore the small tertiary sector and the allegedly universal free education potential.

Those educationists, for example, who, in the 1970s and 1980s saw education as a major factor in development, have cause, given the ravages of HIV/AIDS on teachers, lecturers, civil servants and other western educated personnel, to consider a revision of the means of achieving this process.²²² Donors, as we saw in Chapter Four, are major players in the HIV/AIDS containment campaigns. Donors, however, tend to prefer programmes (and environments) which promote information provision in the hope of securing behaviour change; to the donors this is a pre-requisite for development (Fredland, 1998: 547- 568; DFID, 2001; USAID, 2000: 47 -53). It is argued that, perhaps donors sometimes miss the point that development, via its ability to induce socio-economic change, can be a pre-requisite for behaviour change.

Thus, donors would tend, for example, to promote female education (Munthali, 2001: 168) although, given Malawi's current rural socio-economic environment, these attempts are neutralised by largely unaltered cultural and economic forces. Service provision is, naturally, the province of the resource strapped and priority skewed Malawi governments (Cf. World Bank, 2000; Reserve Bank of Malawi, 2001). This study suggests that the current model of education provides high information and inadequate critical education. In this context HIV/AIDS prevention can only have a limited theoretical, rather than practical, impact.²²³

²²¹ Even the process of negotiating examinations is fraught with extra hazards: the Malawi National Examinations Board (MANEB) has, in the last five years, consistently failed to produce examination results on time. In 2001, 47,218 (out of 82,530) passed the junior certificate examinations, and 11,143 (out of 61,856) passed the Malawi Certificate of Education examinations (*Daily Times*, 13/3/2002).

²²² Personal debates with notably, Jack Mapanje, 1991 – 2002; but also with other educationists like Patrick O'Malley (1993 – 2002); Felix Munthali (1998); David Rubadiri (1996 – 1998) and others.

²²³ This parallels the arguments of the colonial era that saw Christianity as being able to 'civilise and

When educationists are seeing many of their students and students' students dying of HIV/AIDS, placing sole or major hope on a strategy that is in crisis is questionable. This point is crucial to the suggestion in this thesis that a direct attempt by western medicine/health promotion concepts at engaging directly with the village culture to involve the majority of those who do not benefit from prolonged western education and are thus educated by traditional culture may, in the short to medium term, be more appropriate in the case of HIV/AIDS prevention.

4.14 Current Cultural Perspectives

The aim of this section is to review more recent oral and written literature obtained during my fieldwork to give an idea of current contextual background.

A poem by Gracious Changaya (2000) graphically reflects the contradictions between observed ritual behaviour in the cultural arena in relation to HIV/AIDS and the underlying reality. It is worth quoting in full:

*Had he died of 'diarrhoea'
the master of burial ceremony
would have pronounced it easily
without beating about the TB bush*

*Had the death cause been cancer,
pneumonia, anaemia or malaria
that bereaved uncle would have said so*

*Had heart attack been the cause
those lengthy biographies
and mysterious witchcraft stories
wouldn't have covered the coffin*

*But because it was AIDS
the fatal-stone was better left
unturned
Is it a taboo then
to mention HIV/AIDS at a funeral?*

westernise' Africa out of its vibrant indigenous cultures without changing the socio-economic substrata.

In 2000, people were, as the poem shows, more likely to deny, not the existence of AIDS, but the fact that AIDS had taken their dear one. A number of other oral and musical texts reflecting this include Billy Kaunda's (1999) *Mtundu wanga (my people)* and *Tikutha (we are perishing)* by Dennis Phiri (1999). The latter is a song worth quoting in part:²²⁴

Tikutha! Tikutha anthu! (We are perishing, people we are perishing!)
Ine chomwe ndaona (What I have seen is this,
Satana wamanga masiku, (Satan is now in charge)
kulamulira aliyense; (controlling everyone.)
zibale ziti zipita? (which relative will go next?)
Maliro ndi akale (Death has always been with us)
koma lero zanyanya (but now things are too much!)
Tawafunseni agogowa (Ask grandmother)
momwe zimakhalira kale. (how things were in the old days.)
Magulu onse a wanthu (All groups of people)
alowelera inu (are engaged in this process,)
sitikuopa kuti kunjaku zinthu zabeba (not fearing that out
there things are now bad.)
Imvani anthu kusewera ndi moto (See people playing with fire,)
ungadzioche chabe (you will merely burn yourself.)
Chala mkamwa mwa njoka (Sticking a finger in a snake's mouth)
ndikudziputa dala. (is asking for it)

Refrain:

Tikutha! Tikutha anthu! (We are perishing, people we are perishing!)
Taganizani inu ku mortuary (Imagine at the mortuary)
kusowa koponda inu, (you cannot find a space to step on,)
abale athu ngunda ngunda ngati achitira dala (your relatives lying there
scattered on the floor as if play acting.)

Tikutha skillfully utilises both Christian and traditional standpoints, as seen from an experiential position, to paint a graphic and epidemic rise in deaths. These deaths are blamed, in sequential order, on 'playing with fire', 'abundance of sin' and 'deliberate activities of the night in the full knowledge of the consequences'. The results of the epidemic disease are such that the mortuaries are overwhelmed, either through inadequacy or lack of care, reducing the dignity of the dead who are now made to appear 'as if playacting'. Underlying the text is an assumption that the

²²⁴ The full text is in the appendix.

causation of the epidemic disease is known, since the victim is seen to be 'playing with fire' (see full text in index).

In this scenario the maidens too, perhaps so materially desperate, have lost their fear of death, an aspect mistaken for fatalism in the HIV/AIDS discourse in Malawi (Kishindo, 1995: 159; PANOS/UNAIDS, 2001. When consequences (illness) ensue, a denial occurs and the victim is reduced to reconstruct the witchcraft scenario. This gives him an excuse for seeking medical help and legitimises the selling of all the man's goods to pay for his treatment at the expense of his wife and children's inheritance. The family is left destitute, and in the wife or ancestor's case, with an accusation of witchcraft hanging over them. The homestead is effectively reduced to penury. There are echoes here of the suggestion that the death of a husband effectively kills off the family; the wife and children being placed under the uncle's care, an example of the pauperising effect of the lack of a father in a male dominated society (Cf. UNIMA, 1997).

The song is not only interesting for the HIV/AIDS awareness it carries, but for a number of other reasons. First. It is notable for its use of a funeral *ingoma* rhythm. This is itself evocative of a traditional response to death. So powerful is this evocation that when I played this song during a function for diaspora Malawians in Liverpool in October 1999, I was asked to stop playing it.²²⁵ Second. For its engagement with the various socio-cultural and medical discourses of religion, ancestral worship, witchcraft, gender inequality, as well as its allusion to the cost of living (governance) in the cost of cement.²²⁶ There are, inevitably, many apparent contradictions, but these reflect the differences, contradictions and epistemologies, which any Malawian HIV/AIDS discourse has to confront. For example, in the old days, the song suggests, sacrifices would have been made to appease the ancestors with resultant relief from the epidemic. This appeal to old certainties is not too dissimilar to the religious response to HIV/AIDS for most of the eighties and nineties, too much sin, or as often stated in

²²⁵ By D Lizi, a Malawian nurse with a good knowledge of Ngoni culture. This was at a happy party.

²²⁶ President Muluzi's name was, at the time of the song, associated with some cement retailers in the press. The price of cement had just been raised and some were finding it difficult to erect headstones at cemeteries. Here there is an implied critique of the role of governance in inflation. Despite *[ku]pita kumaliro* (the attendance at funerals), the inflation interfered with (raised the cost of) funeral rites.

Malawi, 'the wrath of God'.

Because the text utilizes or engages a mixture of Christian, ATR and popular music discourses, the essentially developmentalist vein of the song may not be obvious, yet this is the author's intention. He warns, not only that we are perishing, but at a rate greater than even in pre-colonial times. Such a bleak wake-up call would be even more potent if students and the young (his target) had been sufficiently educated about their past. Yet the educational system in Malawi was, in 2001, more likely to teach them 'John Brown's body' than *Balala! Balala! Mabvuto mbuyumo! Tiye ni tithawe!*

4.15 Current perspectives on HIV/AIDS

In my fieldwork visits, I found that there was a high degree of public denial towards HIV related illnesses and deaths. I observed this scenario in a number of instances. There were instances where the relatives were in a position to definitely know, and did know that HIV/AIDS was the cause of death, and also those, usually rural, scenarios where the family perhaps genuinely did not know about HIV/AIDS being the cause of death. There were also instances where the refusal to mention HIV/AIDS was motivated by the need to respect the privacy and dignity of the family and the deceased. The person giving the eulogy, either in consultation with others or on his own, chose whether to reveal the real cause of death or not (Personal observation, funeral July 2001). As in the poem above, in a number of funerals the reasons for the deaths were usually given in vague terms, which implied foul play or the mysterious hand of God. However, in appropriating witchcraft discourse, even vaguely, in an effort at preserving the dignity of the deceased, the patterns and trends of blaming HIV/AIDS deaths on *ufiti* tended to be perpetuated. The history of an illness, in one case I witnessed, which had lasted several years, was condensed to give the impression of a young person mysteriously cut in his prime. The balance of "privacy and dignity" versus the clearly visible debilitating effects the HIV/AIDS during the deceased person's life was, in a number of cases, not properly addressed, leaving the family's reputation only redeemable among those who genuinely believed the *ufiti* scenario.²²⁷

²²⁷ Many mourners will, from the disease progression, be aware of the possible HIV/AIDS link.

There is thus a communal complicity of denial set up and perpetuated from funeral to funeral.

In one, a traditional practitioner was invoked to neutralise the perceived spell or sorcery that had been inflicted on the family. This intervention by traditional practitioners at these crucial (when family members are vulnerable) times is important in the socialisation process that perpetuates their role in *ufiti* discourse.

In my discussions with students I was struck by the persistence of certain beliefs, which have, to date, been authoritatively disputed, by medical science. One of these involved the mosquito/HIV question. In a short focus group discussion with theological students at Zomba Catholic and with the senior theology class at Chancellor College this issue arose. Perhaps because of Dr Chakanza's teaching, the senior theology class seemed more aware of the various aspects of this issue, and of the debate between traditional and western medicine in general.²²⁸ The relevant question here was: 'Do mosquitoes transmit HIV?' My answers that science had not so far provided the answer that they do, and had in fact stated that they do not, were not sufficient and the questions kept coming. The class was silenced by my stating: 'I would guess that most of the Europeans and Americans in Malawi (and those Malawians who can) would leave the country if it comes to pass that it was proven that mosquitoes transmit HIV'.

It was not the last time I would find a practical answer more effective than a theoretical one.²²⁹ The students saw HIV/AIDS in socio-economic terms; thus those with mosquito nets (the rich and the expatriates) may avoid getting HIV, if it is transmitted by mosquitoes.

With reference to sexual mores, I was able to confirm that the concept of *kutsekereza* (immunising spouse against temptation while away) and its opposite, the use of love portions to attract a desired member of the opposite sex are still well known, current

²²⁸ His research interests are in theology, African Traditional Religions and African culture (see Chakanza, 2001).

²²⁹ HIV/AIDS has a class/racial dimension in Malawi based on, as previously stated, ability to own mosquito nets to prevent the mosquitoes alleged to transmit HIV; as well as on the ability to afford condoms, adequate nutrition and the expensive treatments.

and respected concepts among some Malawians.

In 1994, the Muluzi administration also pledged to prioritise HIV/AIDS. My observations in 2001 were that it had yet to fulfil these promises. For example, to get a free HIV test, for non-medical reasons, a Zomba resident has to travel to Blantyre, where the USAID backed NGO Malawi AIDS Counselling and Research Centre (MACRO International Inc) is based.

While funds have been garnered from external supporters for other projects, my examination of the 2000 and 2001 government budgets show that family planning, sexual health and HIV/AIDS services have remained, by comparison, relatively low priority areas.²³⁰

And yet the 1999 – 2004 NASF objectives are predicated on donors financing the bulk of it.

But in 2002, the Danish government, one of Malawi's major donors in the related NGO sector withdrew economic aid. There was some controversy about the decision, particularly as the Danes stopped funding educational programmes. The Danish government cited 'corruption and misuse of donor funds by the Malawi government' as the reason for their suspension of aid.²³¹

Across the spectrum of service needs and provision this theme of intention or aspiration is pervasive. For instance, the advertising for *Cafenol* (paracetamol) is always underlined by the phrase: 'If there is no improvement within three days, see your

²³⁰ In 2000, the Malawi government purchased 39 top of the range Mercedes Benz vehicles intended for use by cabinet ministers. After protests by donors, the government decided to sell them and recoup the expenditure. In January 2002, the same vehicles were still in government hands and being used for a SADEC (Southern African Development and Economic Council) meeting. See, for example, Chafunya, T. 'IMF queries delay in Apex, PCC cases', *Daily Times* (13/3/02) at <http://allafrica.com/stories/printable/200203130003.html>

²³¹ A combination of political change in Denmark (from a liberal to a more right of centre government) and a personality clash between President Muluzi and Ambassador Orla Bakdal (in which Bakdal allegedly insulted the President) appears to have contributed to the withdrawal of Danish aid. See *Malawitalk* archives (13/3/02) at <http://www.mailtalk.ac.uk/cgi-bin/wa.exe?A2=ind0203&L=MALAWITALK&P=R14077>

[western] physician'.²³² Yet Malawi has only one doctor for every 40,000 inhabitants and the odds of an ordinary person seeing a doctor because *Cafenol* has not worked are very remote. Yet this form of advertising is the norm.

Medical and pharmaceutical advertising, government information discourse and other radio programmes based on western medical concepts present issues as if the majority had access to the resources discussed. Thus, at a national level presentational behaviour towards western medical access has an aspirational quotient, as if it was not recognised that the majority have no means of affording contact with a 'doctor'.²³³

4.16 Chapter Conclusion

The chapter has traced the unfolding of the HIV epidemic in Malawi. It has shown how educational, medical, economic, cultural, political, religious and other factors affected the responses to it and, consequently, its magnitude. It was, for example, demonstrated how some similarities of *tsempho* and *kanyela* diseases may have affected the perception of the rural population to the new disease.

The limited dialogue between traditional and western medicine, despite the former's major service provision role, was highlighted. The point was made that, as under colonialism, the western model of public health promotion and treatment, for economic and social reasons, can only reach a limited segment of the population. As a result it was shown that due to this failure to engage localised traditions early, some foci of HIV infections will prove difficult to dislodge.

From this history of HIV/AIDS in Malawi, a number of questions arose, such as the capacity of an elite male and business dominated and led government to act proactively in an environment where 'HIV/AIDS activism', as is found in South Africa or

²³² *Panado* and *Cafenol* are trade names for Paracetamol.

²³³ This still echoes the national use of the print and radio media by the colonial government where the messages were mainly for whites. The African radio service introduced later catered for elite Africans. The integration of the services at independence initially ignored the gap between the elite and the peasantry. The Chipembere (1965) and Chisiza (1967) insurgencies made Dr Banda's government revise this policy; introducing many programmes for rural audiences and facilitating the establishment of the *Nzeru* radio company.

USA, is at a minimum. Certainly Muluzi's government has, after half a decade, now acknowledged the magnitude of the problem.²³⁴ But there is still no corresponding commitment to action; the Malawi government, between January and May 2002, in the middle of a famine, was seen to be prioritizing spending on elite luxury items, international conferences and other government expenditure that have no direct immediate or median term relevance to people's welfare over health and social and food security (Cf. Gunya, 2002, Arden, 2002, Ziyaye et al., 2002). And this was despite the donor's strictures. Interestingly, these are the same donors on which the NASF is dependent.²³⁵

It is prudent to note that by the end of 2000, the HIV rate among those aged under-15 years was 2.2% (MNACP, 1999: 21), exactly the same rate first found among pregnant antenatal clinic attendees in 1985. The rate among the 15 – 49 year olds is at 16.4% (ibid). There is thus a potential, as happened last time, for another epidemic starting from this under-15 base.

Having addressed these key contextual concerns of education, culture, politics and medicine that inform the study from theoretical and historical we now turn to the fieldwork.

²³⁴ Personal communication with President Bakili Muluzi, (London 14/10/01). The President, like his then Health Minister, Aleke Banda, was well aware of the magnitude of the HIV/AIDS epidemic and the importance of the donors in the success or failure of Malawi's NASF.

²³⁵ The donor dependency nature of Malawi has been highlighted by recent events, particularly the December 2001 – May 2002 famine. Arden blamed the famine on a number of factors: heavy rains in 2000 and 2001 causing some maize to rot; drought in 2002; government complacency; disputes with donors over governance leading to aid withdrawal and the ending of the seed and fertilizer annual 'starter packs' provision; the selling off of national maize reserves to Kenya in May - June 2001 by companies controlled by *achikulire* (senior government figures); maize price-rises as a result of the produce scarcity; and population growth (*Nkhani za ulere*, March, 2002).

As at 3/3/02 only Canada has pledged some funding for the NASF (*Daily Times*, 27/02/02). Britain and other European Union countries are withholding funding, the International Monetary Fund is still negotiating with the Malawi government, and the Danes have stopped all aid to Malawi. This withdrawal of aid has already affected the educational sector previously funded by DANIDA.

CHAPTER FIVE

PREVAILING CULTURAL ATTITUDES IMPACTING ON DISEASE CAUSALITY

5.1.1 *Chapter Methodology and Structure*

This chapter is constructed on the principle that it is sometimes necessary to split the whole into separate constituents, in order to illuminate the whole (Cf. Scheff, 1997: 1 – 18; Latimer, 1997).²³⁶ It utilises triangulation and elements of part/whole (Scheff, 1997: 1- 18) and reductionist methodology (Cormack et al, 1999: 136). It is therefore divided into a number of sections, each section dealing with a different aspect of the cultural dynamic as it relates to HIV/AIDS. The first three sections are designed to link this to earlier chapters. The various strands are then brought together at the end of this Chapter and in Chapter Six.

This is followed by section 5.2, where the reasons, design, methodology and execution of my fieldwork are described.

Section 5.3 provides some continuity between the earlier chapters and Chapters Five and Six by briefly noting some historical continuities relevant to the HIV/AIDS discourse.

Following these theoretical and introductory sections, the sections from 5.4 onwards deal, successively, first with the general markers reflective of cultural traditions in general (5.4) then, specifically, oral discourse, music and language (5.5). This is followed by sections examining each of the specific five markers used in the student survey: *ufiti* (witchcraft) (5.6), *kukhwima* (fortification) (5.7), *Malungo* malaria (5.8), *nyamakazi* (rheumatism) (5.9) and HIV/AIDS (5.10).

Section 5.4 deals with the general cultural patterns in Malawi. It is constructed using

²³⁶ See also <http://www.keele.ac.uk/depts/mn/staff/dkhome/teaching/ThePartwholeproblem.doc>

the general markers of *mdulo*, scarification, the role of women, poverty/wealth, issues of governance, family planning, traditional practitioners, some specific traditional practices, and other relevant factors, like male and female attitudes to condoms, to give the general context in which students and other Malawians experience and react to the issues of HIV/AIDS.

From researching section 5.4, in line with grounded methodology (Glaser et al., 1967), it became clear to me that, in Malawi, orality plays an important role in cultural interaction, dissemination and intercourse; matters of crucial relevance to HIV/AIDS discourse. Therefore, before tackling the specific questionnaire material, in order to further illuminate the context, I sought in section 5.5, to investigate aspects of oral and musical discourse. Section 5.5 shows how examination of these discourses provides valuable insights into the Malawian HIV/AIDS debate.

Each of the sections 5.6 to 5.10 is divided into four parts. The first part gives the results of literature review of previous work. This is followed by the results of my own wider socio-economic data collection into each of the subjects where I set out the general context of the specific findings. Following this are the results of my quantitative and qualitative surveys.

In all sections the intention is to assess prevailing discourses and cultural attitudes of relevance to HIV/AIDS. The final section provides further analysis and conclusions.

5.2 Methodology

The purpose of this field work was to study how the postulated dynamic between politics, culture and medicine is (i) constructed and (ii) how it is maintained to inform contemporary medical beliefs, attitudes and behaviour particularly among Malawians aged between 10 and 25, with special reference to HIV/AIDS. I sought to do this by designing questionnaires that would give insights into the students' awareness of HIV/AIDS, as well as the broader underlying issues of awareness of and use of traditional and western medicine, awareness of and beliefs in *ufiti* and *kukhwima*, and the role of parents and family in these issues. I also wanted to find out their views on

causality. The fieldwork was also intended to enable collection of background data against which to contrast my specific findings among students.

5.2.1 *Fieldwork overview*

This fieldwork, as would be expected of a triangulated multi-disciplinary study, involved a number of components: (a) the historical perspective, designed to add to the historical data I had previously obtained in the UK and Malawi (b) the qualitative components and (c) the quantitative aspects.

By separating the literature review sections from those detailing prevailing cultural contexts, and by cross referencing these to the earlier chapters, and to each other, a clearer idea of change and continuity can be appreciated.

The historical perspective was required to give an idea of how the present cultural, economic, social, medical and political context has arisen (Marwick, 1970: 17). Historical research tends to offer chronological and contextual explanatory dimensions (Thompson, 1986: 4). Context, chronology, change and continuity, as well as shifting values among historians as well as the society in which they act, come into play. Malawian history could be periodised into a number of historical phases, for example: pre-colonial, colonial, the first postcolonial regime and finally, the second postcolonial or multi-party regime. Each has its own distinctive socio-cultural and political dynamics.

The historical perspective required the collection of as much relevant published data and archival documents as possible. I also undertook oral interviews. The published data included newspapers, journals and magazines.

The qualitative aspect, on the other hand, aimed to collect in-depth descriptive, ethnological and phenomenological data about current human social contexts and worlds in order to understand the qualities or characteristics of these contexts; contexts 'frequently too complex to yield to simple description' (Robinson and Reed, 1998: 83 – 84). Qualitative methodology by permitting the valuing of subjective data, flexible design methods and the use of a number of tools – as in my case - including questionnaires, in-depth interviews, case studies, participant observations and analysis of written, oral or broadcast conversations is useful in studying a complex phenomenon

like HIV/AIDS. As Gillham asserts, qualitative research is basically a search for meaning (Gillham 2000: 10).

Therefore, one of the instruments I utilised was participant observation, a tool that enables the researcher to discover the 'nature of interaction in a social setting, and to illuminate the understandings and motives of those involved in the interactions' (Cormack, 1998: 120). As oral and musical discourses are important to the HIV/AIDS debates in largely oral cultures, methods of assessing everyday discourse were essential. Consequently, I recorded text, musical and oral data for later analysis, using audio and video equipment. I also gathered some data by actively monitoring the radio and by noting and studying daily oral discourses.²³⁷

I designed semi-structured qualitative questionnaires, which included open and closed questions with space for free-text comments.²³⁸ In line with Oppenheim (1992) I attempted to ensure that the format would be easy to understand, easy to complete and able to obtain the information I was seeking. The questionnaires were designed to be self-completed by the students themselves. Some of the questions in the qualitative survey were amenable to quantitative analysis.

The quantitative questionnaires were mostly closed and were intended to give a more value-free, systematic and objective measure of my respondents' beliefs, complement the qualitative data and add more depth to the study. The inclusion of quantitative aspects to interrogate the same qualitative information has utilised elementary aspects of numerically aided phenomenology (Cf. Kuiken et al., 2001), to bring out or more accurately define the extents of phenomena. I use this for example to quantify those who stated that they might use *kukhwima* fortification.

The questionnaires included questions utilizing elements of the Likert scale (Likert, 1932) and the Expectancy Value approach of Fishbein and Ajzen (1975) testing all three components of attitude: the evaluative, belief or cognitive and the behavioural. Both the qualitative and quantitative interviews used two diseases, two socio-cultural phenomena and one symptom as key markers to focus the questions and responses.

²³⁷ In a largely oral culture like Malawi's it is important to assess the contents of this space and to contrast it with information from written sources.

²³⁸ I am grateful to Chris Martin for a helpful critique of earlier versions of the questionnaires.

The markers were chosen in such a way as to give a balanced view of attitudes towards HIV/AIDS, culture and medicine in general. The markers were: a. Malaria (*Malungo*). b. HIV/AIDS (*Edzi*). c. Fortification (*Kukhwima*). d. Witchcraft (*Ufiti*). e. Rheumatism (*Nyamakazi*). In the questionnaires I sought to establish a cross sectional sample of primary, secondary and tertiary student views on *ufiti*, *kukhwima*, HIV/AIDS, malaria and rheumatism.

Crucially, as this study examines how the prevailing cultural attitudes impact on causality, it was important to include references to causality. The Quantitative and Qualitative Questionnaires are in Appendix 3 and 4 respectively.

A number of focus group discussions (FGD) were undertaken. FGDs are believed to be useful tools for gathering information on sensitive and private subjects, particularly in some traditionally sensitive contexts. In informal and spontaneous groups and settings people often open up much more than in one-to-one interviews (Cf. Krueger, 1994: 15). However, apart from the more formal FGD, there were other more informal discussions, for example those with musicians. The contexts of some of these were in line with Burgess' (1984: 5) assertion that triangulated ethnography involves developing 'relationships between the researcher and those researched', relationships which facilitate the further gathering or checking of information. It was for example in such a setting that I was able to obtain more of some of the meanings of phrases used by *alangizi* (counsellors) musicians in their discourse.²³⁹

Participant observation of every day cultural activities and discourse, through interacting with family, academic colleagues, the general public in markets, schools, places of worship and entertainment, as well as attending funerals was undertaken.

I also interviewed some key informants, such as traditional medical practitioners, doctors, nurses and herbalists.

²³⁹ For example: the use of the term *m'bala ndiwo* (lit. one who begets relish). The term was used to denote the fact that [in the song] all his children were 'eaten by witches'. The implication that witches were serially killing his many progeny effectively reduced him to a 'meat producer' (*m'bala ndiwo*). I was particularly grateful to Saleta Phiri, George Mbendera and the Kasambwe Brothers.

5.2.2 Background

My fieldwork planning was informed by previous visits to Malawi. For example, on 21st December 1993 during a four-hour drive from Lilongwe to Malindi I had a long conversation with my brother Mike on the role of *kukhwima* in politics. He thought, then, as did other young Malawians (Cf. Chapter One, section 1.2) that one had to be 'fortified' to be a successful politician. My previous researches had produced substantial primary and secondary data on Malawi, particularly the period after 1961. Then from March until June 1994, I had first hand experience of interacting with future power brokers as a Shadow Cabinet member. Although I did not make the transition to full time politics, these contacts and experiences at a time of transition, socio-political restructuring and elite confrontation and compromises were extremely instructive. From a clinical perspective, between September 1994 and June 1995, I had observed the cultural/medical dynamic at first hand; noting how rural and urban patients would be removed from the wards at weekends and returned - after consulting *sing'angas* (traditional practitioners) - in time for the ward rounds on the Monday morning. I had interviewed nurses, clinical officers and junior doctors on this phenomenon; most agreed that both belief and pragmatism were factors.²⁴⁰ I also interviewed herbalists, like Fili Malanga, then based at the TB Hospital, Lilongwe.²⁴¹

5.2.3 Aims, designs and methods

It was intended to:

- Carry out qualitative and quantitative surveys of attitudes towards traditional and western medicine among urban and rural dwellers in Blantyre and Malindi. These aimed to elicit attitudes towards, and beliefs, in traditional medicine from among various groups aged 10 to 25.²⁴² Both the qualitative and quantitative questionnaires used the key markers to focus the questions and responses:

²⁴⁰ Here I am grateful to Dr Sam Kampondeni, then a medical registrar at Lilongwe Central Hospital, for his advice to respect patients and relatives views in this process.

²⁴¹ See Lwanda (1996: 101).

²⁴² Because of the use of self-filling questionnaires I wanted the students to be able to read Chewa or Yao. Most university students graduate by about 24 – 25 years of age.

Malaria, *Malungo*; HIV/AIDS, *Edzi*; Fortification, *Kukhwima*; Witchcraft, *Ufiti* and Rheumatism, *Nyamakazi*.

- Undertake some participant observation, attending educational and cultural events, funerals and political meetings.
- Interview some key informants, traditional practitioners, doctors, nurses and local leaders.
- Collect some written historical or contemporary data: from archives, newspapers, journals and magazines, as well as to undertake some audio and video recordings. This data was of prevailing references in the wider socio-cultural environment to the key markers, as well as to poverty, class, wealth, issues of governance, heterosexual relations, family planning, traditional practitioners, the role of women, specific traditional practices, attitudes to condoms, and some issues of socialisation, typified by the persistence of the *mdulo* (sexual avoidance taboos) concept and other traditional cultural markers like scarification.

Thus after my field trip I expected to have the following data:

- Historical and other data from Malawian archives and libraries.
- Oral histories and testimonies from interviews.
- Quantitative survey data on attitudes to traditional and western medicine from the rural Malindi and urban Blantyre.
- Qualitative data from the Malindi survey.
- Qualitative data from Blantyre survey.
- Participant observatory data from fieldwork.
- Other relevant data found.

A potential problem was that of language. Although most Blantyre and Zomba people speak Chewa/Nyanja, Yao and English, there are significant Tumbuka, Tonga and Lomwe minorities in Blantyre. Using English in my questionnaires was intended to overcome this problem. Thus the questionnaires were structured in such a way that each question could be accessed in English, Chewa or Yao.

Reflexivity

I found that my occupation, personality and age were relevant to how I was perceived by my respondents. At a personal level old age is still revered. On 5/7/00, for example, during my focus group session at Zomba Catholic Secondary School, I provoked immense discussion by revealing that I was a student there between 1964 and 1967 (the teacher who was coordinating my session, Mr Charles Nsitu, was not even born then). The students, though irreverent in manner, were awed by my *mdala* (old man) status, a reflection of attitudes towards those older than themselves. The amazement that one could live so long and still be involved in studies was also voiced.²⁴³ This reaction led to a spirited short discussion of HIV/AIDS, education and aspects of *ufiti* discourse.

There were times when I was aware that I could not get out of my medical doctor persona. Some of my informants were intrigued that a medical doctor, perceived as being 'scientific', was interested in researching issues of culture and *ufiti* discourse. Some of this group, once satisfied that this was a serious attempt at getting some answers to a difficult problem, gave some of the most impressive answers. This was the case with two of the *sing'angas* I interviewed. At times I had the impression that respondents wanted to give 'expected' or 'received wisdom' answers.

I was also aware that, as a fairly well known personality among academic colleagues at primary, secondary and tertiary level centres of education, the introductions which colleagues gave, while all helpful, affected the initial responses to the questionnaires. For example the First Year English class approached them more hesitantly, like an examination, unlike the First Year Philosophy class which adopted a more straight forward approach.

I tried, as much as possible, to remain aware that my own personality and background could influence respondents reactions.

²⁴³ The average life expectancy in Malawi is now said to be about 40 (UN IRIN, 21/2/02).

5.3.4 Modifications to the field trip

After arriving in Malawi, I had to make several alterations to my fieldwork for several reasons. First, as I was going to be based in Zomba, it was easier, and more economical, in terms of time and expense, to carry out my urban questionnaire surveys in Zomba. Like Blantyre, Zomba primary schools reflect the ethnic diversity of this ‘University, Army Garrison and Regional Police HQ town’. Zomba, although not as industrialised, has the same multi-ethnic mix as Blantyre. Zomba also has one of the largest markets in the country which provided me with ample opportunity to sample daily oral discourse. Second, all the members of staff at Chancellor College I approached were very co-operative and provided me with an opportunity to survey a large number of their undergraduates. In this regard, the sampling of the first year Chancellor College Humanities and Philosophy students – newly arrived from various districts that very week - effectively gave a nationwide perspective of post secondary education opinion, adding an extra dimension to my samples. Third, undertaking questionnaire surveys in Zomba, rather than Blantyre, enabled me reduce the commuting to Blantyre and spend more time at the Malawiana Collection (Chancellor College Library) and the Malawi National Archives. Fourth, Zomba also provided a number of very cooperative primary and secondary schools.

From the Table 4 it will be noted that the schools chosen represent elite schools, in terms of – to varying extents - funding, staffing, connections to influential powerbrokers and access to external donor resources. Zomba Catholic and St. Mary’s Secondary Schools are Catholic run and supported. St. Michael’s Secondary School is an Anglican run national secondary school for girls, which takes students from all over Malawi. Mangochi Secondary School benefits from being the main district secondary school and has some external contacts via its Canadian volunteers. St. Martin’s Primary School, an Anglican run school, also benefits from overseas contacts. Bwaila, one of the urban Zomba primary schools, is patronised by the children of many of the town’s civil servants; this is also true of Masongola Secondary School. All these schools therefore are better resourced and staffed than most other schools in these districts.

The sites surveyed and the numbers of respondents are shown in Table 4.

Table 4: Sites of questionnaire surveys.

Chancellor College (All the Senior Theology class of Dr Chakanza)	n=19
Chancellor College (All the Second Year Theology of Dr Chakanza)	n=33
Chancellor College (All the Second Year Biology class of Dr Ambali)	n=23
Chancellor College (All the First Year English class of Dr Kayambazinthu)	n=131
Chancellor College (All the First Year Philosophy class of Prof Mwaipaya)	n=74
<u>TOTAL UNIVERSITY</u>	<u>n=280</u>
Zomba Catholic Secondary School, randomly selected students, from forms 1 to 4.	n=55
Masongola Secondary School, randomly selected female students from forms 1 to 4.	n=50
St. Mary's Secondary School, randomly selected students from forms 1 to 4.	n=50
St. Michael's Girls Secondary School, randomly selected students from forms 1 – 4.	n=261
Mangochi Secondary School, randomly selected students from forms 1 to 4.	n=57
<u>TOTAL SECONDARY</u>	<u>n=473</u>
St. Martin's (Malindi) Primary School, Mangochi, randomly Selected students from Primary 5, 6, 7 and 8.	n=100
Bwaila Primary School, Zomba, randomly selected students from Primary 5, 6, 7 and 8.	n=94
<u>TOTAL PRIMARY</u>	<u>n=194</u>
<u>GRAND TOTAL</u>	<u>N=947</u>

5.2.5 Procedure

At all sites the following routine was followed: Prior requests and arrangements were made for the questionnaire filling sessions with the Department Heads and class lecturers (Chancellor College), and with the Heads at the secondary and Primary Schools. At the primary and secondary schools the headmaster delegated the random selection of students to the teacher who had been chosen to assist me. This varied from the youthful Mr Nsitu at Zomba Catholic, a female Canadian volunteer at Mangochi Secondary School, to Mrs Chalira (the Head herself) at St. Michael's Girls Secondary School. The numbers were dictated by the size of classrooms. Apart from Malindi Primary and Mangochi Secondary School (where two class rooms were used) and at St. Michael's (where the dining room was used), all respondents were in the same class or lecture room. At Masongola I had requested that only female secondary students be recruited, as I required more urban-based female students to compare with those at the rural based St. Michael's College. At all sites the students were either randomly chosen or the entire classes were included.

On the actual day the following routine was followed: First I either introduced myself or was introduced by the teacher/lecturer. I limited myself to stating that I was, in the context of HIV/AIDS, investigating the traditional and western medical services in Malawi. The students were then randomly given either a qualitative or quantitative questionnaire and asked to self-fill these documents. Table 6 shows the numbers of quantitative and qualitative questionnaires used. Recognising that it might be problematic for some to put their own names on the questionnaires while answering questions like *ufiti*, I made it optional for them to fill them anonymously. For the purposes of the study their class, age, handwriting and school became sufficient. This appears to have encouraged some respondents to be more forthcoming. Those who desired anonymity were asked to merely identify themselves with their class and age. It was explained to the respondents that this was not an exam but a request for their opinions. The impression that it was an exam appeared to have affected the respondents in the first year university classes and those at Masongola and Mangochi Secondary

Schools.

All students were allowed to fill the forms at their own speed; the rates of completion varied from 15 minutes to one hour. I was present throughout the completion process, answering any queries and collecting the questionnaires at the end. Sometimes I successfully persuaded respondents to fill in sections they had omitted. The most common problem encountered was item-nonresponse of the forms. As the worst sites were the First Year English at Chancellor College and St. Michael’s Girls Secondary School,²⁴⁴ and not the primary schools, issues of literacy and understanding did not appear to be a problem with the questionnaires. Time constraints affected some of the respondents. This led to some of the questions on the questionnaires being unanswered. Some of the questions were left unanswered even by some of those who finished on time. The questionnaire was designed in such a way that each question, although part of a whole, stood on its own. Thus even from uncompleted questionnaires answers to specific questions could be used.

With regard to the quantitative results it is stressed that the intention was to give an idea of the magnitude of awareness, beliefs or knowledge to complement the qualitative data as part of the triangulation. This quantitative information is used as it stands with no attempts at averaging it or calculating correlation coefficients. Table 5 shows the numbers of students sorted according to their levels of education.

Table 5: Students surveyed sorted according to level of education.

Senior university students	19
Junior university students	56
First year (freshers’ week) university students	205
Secondary School Students	473
Primary School Students	194
TOTAL	947

²⁴⁴ This may be partly explained by the fact that it was (St. Michael’s) a lunch time session.

Table 6: Types of Questionnaires.

Site	Qualitative	Quantitative
Chancellor College		
Senior Theology, Dr Chakanza's class	09	10
Second Year, Dr Chakanza's class	12	21
Second Year Biology, Dr Ambali's Class)	00	23
First year English, Dr Kayambazinthu's class	98	33
First Year Philosophy, Prof Mwaipaya's Class	60	14
Zomba Catholic Secondary School	16	39
Masongola Secondary School, Zomba	18	32
St. Mary's Secondary School, Zomba	21	29
St Michael's Girls Secondary School, Mangochi	202	59
Mangochi Secondary School	15	42
St. Martin's (Malindi) Primary School, Mangochi	43	57
Bwaila Primary School, Zomba	61	33
TOTALS	555	392
GRAND TOTAL	947	

5.2.6 Focus Group Discussions

Focus group discussions were held at Malindi Primary School, St. Mary's Secondary School, Zomba Catholic Secondary School, Masongola Secondary School, and with the Theology and Biology classes at Chancellor College. These varied from short ten to fifteen minute pre-questionnaire filling discussions at Malindi Primary and Bwaila Primary School to the thirty-minute sessions with theology students at Chancellor College. The commonest questions asked of me were about mosquitoes transmitting HIV, the actuality and effectiveness of *ufiti* and my views on the efficacy of traditional

medicine. In their focus group discussions both classes at Malindi rated Malaria, AIDS and *ufiti* as some of the main problems in the area.

The focus group discussion at St. Michael's College proved unsuccessful because of the large number of students involved. The residual group of nearly fifty degenerated into a show of bravado and it became difficult to focus the discussion on anything other than *ufiti*, a subject topical at Malindi at the time.²⁴⁵

5.2.7 Qualitative Interviews

Semi-structured interviews were held with a number of selected members of the public. These included academics, doctors, businessmen, village leaders, and taxi-drivers. I was particularly keen to interview people involved in information dissemination. These qualitative interviews were based on the Qualitative questionnaire given to the students.

5.2.8 Participant Observations of Cultural Activities

I attended and recorded performances by the Kwacha (Malawi) National Dance Troupe (27/6/00 and 15/7/01). Malawian traditional dances encompass the variety, resilience and strength of Malawian culture. Of relevance to this study is the sexual explicitness inherent in some of the Malawian traditional dances, one of the reasons advanced for the objections of missionaries and colonial authorities to indigenous traditional dances. This sexual explicitness is sometimes tentatively used in AIDS awareness drama or theatrical settings. It is thus an ambiguous tool in HIV/AIDS discourse, being seen as both permissive and educational.

I also attended a number of popular music concerts, including Lucius Banda's concert, to observe how music is used as a political and health message delivering tool by popular musicians. On Independence Day, the 6th of July, in 2000 and 2001, I took part in and recorded the festivities at the 'CIVO' (Civil Servants Stadium),²⁴⁶ and Mzuzu

²⁴⁵ It must be admitted that the presence of my taxi-driver, a young man with 'pop star' looks became a distracting point.

²⁴⁶ Banda built this for civil servants, partly to deflect their grievances about their exclusion from the then white dominated places like the Lilongwe Golf Club (Personal communication Zingano, B. and Chavula, S. 7/9/94).

Stadiums respectively.²⁴⁷ I noted the presence of HIV/AIDS awareness posters on the four corners of the stadiums, which contrasted sharply with some of the sexually explicit traditional dances performed on both days.

In order to get an idea of how school students' view, value and experience traditional culture within the context of school, I attended the open school days at Likoma (2000) and Zomba (2001). Visits to Limbe, Blantyre and Zomba markets were undertaken to experience and sample oral discourse. The streets here are mostly licensed informal economies, full of music and talk. The music is intense, mostly social and gospel (Cf. section 5.5.3).²⁴⁸ I participated in market activities, buying food and other merchandise and distributing my own products (compact discs) to a number of vendors. Yet beneath the apparent chaos of the urban markets there is a perfect order, the order of village market transferred to an urban setting; the discourse is very similar. To experience this discourse further, I also travelled extensively using the informal minibuses, the *matolas*. I noted that both the markets and the informal bus networks show the rural pattern of minimal formal policing (Cf. section 1.1).²⁴⁹ This 'minimal formal policing' is consistent with a communal maintenance of order via taboos and other unwritten rules. It is also consistent with pre-colonial patterns of governance.

5.2.9 Interviews with traditional practitioners

I interviewed Swadeki Adini, a traditional practitioner and witch-finder at Malindi and another traditional practitioner, Charles Kumpolota at Likoma. After hearing about him on the radio, I met an urban-based herbalist called Matimati, in Blantyre. These interviews, except Mr Matimati's, were recorded either on audiotapes and/or on video. Notes were taken of Mr Matimati's interview, which was held during a one and half

²⁴⁷ I required the authorisation of the Deputy Inspector General of Police for 2000. In 2001, I obtained a press pass.

²⁴⁸ My impression was that the popular musicians are currently serving most of the functions, which Mphande L (1996: 80 - 101) claimed for the Writers' Group. The Malawi Writer's Group, which included Mapanje, Ken Lipenga, Lupenga Mphande, Janet Karim and other writers critiqued Banda's politics using orature as a starting point. The musicians use folktales and proverbs to make social comments, which are often as biting as that of the writers then. In the multi-party dispensation many of the once critical writers have either been co-opted into elite positions, or, as in the Banda era continue to reside in exile.

²⁴⁹ Police and other law enforcement agencies are ordinarily rarely present in these places.

hour drive from Blantyre to Zomba.

5.2.10 Archival and literature searches

These were conducted at Chancellor College's Malawiana section of the College Library. I found this much more useful for the postcolonial period than the Malawi National Archives. The doctoral and master theses collection is incomplete but very useful. I also consulted the Polytechnic, College of Medicine, Bunda College, Kamuzu College of Nursing, and the Ministry of Health Libraries. All these have varying sizes of Malawiana. Interestingly, the Kamuzu College of Nursing was more useful to my work than the College of Medicine Library. Further searches were conducted at the Heritage Centre, which houses the *Society of Malawi Journal* collection and at the Livingstonia museum.

5.2.11 Press Monitoring

To monitor newspaper and magazine discourse in relation to culture and HIV/AIDS, I bought all the two daily papers, *The Nation* and *The Daily Times*, and the other regularly available weekly papers, *The Business Telegraph*, *The Malawi News*, *The Weekend Nation*, *The Mirror* and *The Enquirer*, as well as the regular magazines, *WASI*, *Pride*, *Moni* and *The Lamp*.

5.2.12 Radio Monitoring

As the radio is the most penetrative medium, I monitored specific programmes for their cultural and medical content over a six-week period in 2000 and a four-week period in 2001. The programmes like *Zam'maboma* and *Mauthenga achisoni* were chosen for their relevance to the present study in that they address: traditional issues, cultural issues, HIV/AIDS, medical issues, health promotion issues, and those of *ufiti*, *kukhwima* and traditional causality concepts.

5.2.13 Recordings

To add depth and currency to the musical analysis I had undertaken, I brought my recorded oral and musical data up to date. As with my interviews and other collected data, I wanted to be able to review the information at leisure. I therefore made extensive use of video, minidisk and audio tape recording methods, utilising a digital video recorder, minidisk audio recorder and a cassette recorder.²⁵⁰ The recordings included:

- The interviews with the two traditional practitioners mentioned above.
- A video recording of Kumpolota's healing service (18/7/00) Likoma.
- Video recording of the school open day at Likoma.
- Performances by popular musicians Saleta Phiri, Beatrice Kamwendo and the Ravers, Lucky Stars, Kasambwe, and the Mulanje Mixers. Each of these groups was asked to sing its most effective AIDS awareness song, and their views on HIV/AIDS were elicited.
- Performances by the Gospel groups, the Mount Sinai Choir, Malindi Choir, St. Georges' Choir (Zomba), and the Evangelical Faith Praise Singers of Zomba. Each of these choirs was asked to sing its most effective AIDS awareness song, and their views on HIV/AIDS prevention were elicited.²⁵¹

5.2.14 Case studies

Although case studies may not be as rigorous as quantitative and other qualitative methods, they are useful for studying contemporary situations, particularly on-gong events (Yin, 1994; Robinson and Reed., 1998: 11; Gillham, 2000). I made case studies of the Likoma and Malindi areas to give context to the areas in which my interviewee traditional practitioners were based.

Having outlined my fieldwork methods, I now turn to a brief resume of the historical dimension.

²⁵⁰ I am grateful to the BBC African Service, and Catherine Fellows, for a loan of a minidisk recorder.

²⁵¹ The choral performances were recorded on video.

5.3 Historical Continuities and awareness of study issues

5.3.1 Historical continuities

The causality debates of the colonial period, as noted in Chapter One, emphasised, and perhaps romanticised, the witchcraft aspects at the expense of their social and utilitarian context and roles (Cf. Evans-Pritchard, 1937; Parrinder, 1956). Indeed some post-colonial studies emphasise the symbolic aspects of traditional medicine. These analyses underplay, and often seem to ignore, the reason for any form of positive medical systems: the prevention of and cure of disease. For the indigenous Malawians these medical frameworks were not just symbolic, but promoted health and provided cures for disease as noted in Chapter Two. This was a framework intimately related to the socio-economic and cultural conditions, and which was used to control epidemics, diseases and promote societal behaviour and health.

We also argued that, since the colonial socio-economic environment did not enable universal western medical services to be accessed by Africans, most of the pre-colonial indigenous medical framework survived, albeit in certain localities. But while territory-wide disease control functions of this pre-colonial framework have been constrained, its role in disease management, as traditional medicine, continues. It is, in this Chapter and in Chapter Six, argued that, given the limited cultural change and westernisation in Malawi, this role remains crucial to the maintenance of social order and health in both rural and urban Malawi.

Similarly, aspects of traditional medicine then could be used both to observe and subvert the communal order, specifically the moral, economic and sexual orders. The moral order subversion, we suggested, resulted in the corruption of some traditional practices into *ufiti* and the corruption of the sexual order taboos in an attempt to evade *mdulo* (sexual avoidance taboos) and other taboos. These corruptions, we noted, could be identified as happening in the colonial and postcolonial eras for political, economic and sexual purposes. For example, in the context of HIV/AIDS, the ability of traditional practitioners in the colonial period to ‘conceal adultery’ (Cf. Cullen, 1932: 232) has

been carried over into the postcolonial era. Kumpolota (Personal Interview, 18/7/2000) and Adini (Personal interview, 10/7/2000 and 30/7/2000) both claimed to be able to treat sexually transmitted diseases of the *mdulo* complex, which we discuss in this chapter.

In Chapter Three we noted the postcolonial resurgence of traditional cultural discourses.²⁵² We highlighted the ambiguity of the Banda regime towards this resurgence (Cf. Lwanda, 1993; Forster, 1994, Phiri, K., 1998 and 2000) but noted that within the hegemony of Banda's MCP there was a yearning for a return to cultural values beyond those prescribed. In 1972, for example, the MCP annual convention delegates demanded

the revival of some positive aspects of traditional institutions and initiation rites through which young people are taught good behaviour and prepared for adult life' (Kamlongera, 1988: 18).²⁵³

These rural-led demands persist. In 1999, for example, Yao chiefs told President Muluzi to change the school timetable (changed after independence) back to the colonial cycle, so that it did not interfere with their initiation ceremonies (PANA archives, 20 October, 1999). There is a normative tendency, given the socio-economic context, to enforce and perpetuate the corresponding appropriate localised practices we identified in Chapter Two. Thus while the colonial and Banda governments were seen as having 'domesticated' many traditional practices, like the *nyau* (religious and cultural movement) common in the Central and Southern regions, these practices had merely found ways of minimising conflict with governance (Cf. Kaspin, 1993). The *nyau* continue to show similar ingenuity while accepting money from the Muluzi regime; the *nyau* are able to continue their postcolonial public activities without giving

²⁵² Good tangible examples of this are: the inculturation debates and practices, the indigenisation of music and the resurgence and strengthening of the extended family systems in the wake of AIDS deaths (Cf. Musopole, 1996; Ott, 2000; Chakanza, 2000; Lwanda 2001).

²⁵³ Despite the apparent total hegemony, there were always minority independent forces in the MCP pushing for different cultural and political agendas. These found voice when Dr Banda's gaze was elsewhere, as when they were given free reign to discuss the issue of culture in 1972. Further it has to be recalled that during the MCP era all public discourse had to take place within the context of the MCP, some non-political issues like culture could only be addressed through the conventions. There was resentment among cultural and traditional leaders of the role of the MCP in constraining cultural activities.

up most of their localised aspects.²⁵⁴ In effect, this acceptance of money is a survival tactic, like the colonial era localisation of some traditional practices. We also pointed at the donations to Banda, from the rural poor, of eggs, chickens, goats, maize as well as their cultural activities and time. These donations did not imply complete submission; it was rather a public recognition of the superior force of repressive governance. This Chapter will show that these localised practices are still vibrant. It will then be argued that engaging these localised practices in a discourse that superficially changes their ontological boundaries does not necessarily affect their epistemological or moral long-term views.

Similarly, Christianity was not seen to have abolished beliefs in *ufiti* in the postcolony. Commenting on his own study, Hopkins (1980: 56) noted

More than a century of Western education and Christian indoctrination has failed to loosen its [witchcraft] stranglehold on the minds and hearts of the African people.

But Hopkins' was a small study (n = 25). All of the 25 theology students said 'yes' they believed in witchcraft; 19 said Malawians believe in witchcraft; and 14 said Malawi Christians believe in witchcraft. The study respondents gave social reasons for witchcraft like: stealing, success, sexual protection and *kukhwima*. I found, in my surveys, that these views are still current.

²⁵⁴ In the sixties *nyau* were such fearsome creatures that passers-by who were not initiated ran away as *Nyau* approached. In the 1970s and 1980s the use of *nyau* in ceremonial national affairs 'domesticated' them in the sense that the public now do not run away from them in daylight or very public roads for instance. This was part of Banda's attempt at 'domestication' of localised practices like *nyau* for political reasons. This attempted domestication of localised cultural practices continued after Dr Banda. In the multi-party era, *nyau* are often seen on roadsides publicly performing for money, albeit on their way to and from their more private functions. The relationship between Muluzi and the *nyau* in contrast to the coercive one with Banda is summed up as 'the *nyau* have been bought by Muluzi'. This reflects the use of patronage funds, accumulated from various sources like Libya, Kuwait, and Lebanon as well as from local Indian and Lebanese business sources, to 'buy' opposition figures or icons. See Lwanda (Seminar paper proposal) 'Kwacha: The violence of money in Malawi's socio-political discourse'. Interestingly, the relationship between the *nyau* and the freedom of the multi-party era is illustrated by the following example. A *nyau* that had fainted from dehydration was heard to intervene (when First Aiders were debating what fluid was best, water or *Fanta*): 'I think the *nyau* will recover quicker with the *Fanta*'. Between 1994 and the 1999 elections, the *nyau* certainly had a public visibility and voice.

5.3.2 Awareness of issues

Before proceeding to discuss aspects of culture in detail it will be more appropriate to present the results of the part of the questionnaire, which assesses the students' awareness of the issues I was studying. The question asked was: Are you aware of rheumatism, malaria, HIV/AIDS, *kukhwima* (fortification) and *ufiti* (witchcraft).

Taking into account the significant item non-response at St. Michael's the Table 7 shows that there was a good knowledge of the issues of rheumatism, malaria and HIV/AIDS at all sites, those for malaria and HIV/AIDS being particularly high. With the possible exception of St. Michael's (for the reasons given above) and Bwaila, with a 41% awareness level, there was a good awareness of rheumatism, an awareness that increased with level of education.

Around a quarter of the primary school children at both sites were aware of *kukhwima*, while just 16% at St. Martin's and 21% at Bwaila were aware of *ufiti*.

With the exception of a low 28% recognition rate at Masongola Secondary, the level of *kukhwima* and *ufiti* recognition rose with age and education, from primary to tertiary. There was no rural/urban dichotomy noted in awareness of *ufiti*. The levels of *ufiti* awareness in my findings were not consistent with Hopkins 1980s suggestion that all Malawians believe in *ufiti*.

These responses show that there was a very high (malaria, HIV/AIDS), good (rheumatism), and reasonable knowledge (*ufiti*, *kukhwima*) of the issues I was researching. It will later be demonstrated that this awareness of *ufiti* (Table 7) when contrasted with the figures in Table Table 17 (*ufiti* causing illness) and Table 19 (*kukhwima* protecting from illness) shows the use of different questions to probe the same idea. For example, even though only 16% at St. Martin's said they were aware of *ufiti*, 42% agreed that *kukhwima* could protect from *ufiti*.

Table 7

The percentages are those, out of all respondents, who replied 'Yes' to the Question:

Are you aware of:	Rheumatism?	Malaria?	HIV/AIDS?	<i>Kukhwima</i>	<i>Ufiti</i> ?
Site:					
Primary:					
St. Martin's n=43	51%	84%	63%	23%	16%
Bwaila n=61	41%	95%	90%	26%	21%
Secondary:					
Mangochi n=15	73%	67%	80%	40%	53%
St. Michael's n=202	37%	90%	77%	11%	10%
St. Mary's n=21	67%	100%	95%	57%	67%
Masongola n=18	61%	100%	100%	28%	50%
Zomba Cath. n=16	78%	100%	100%	39%	61%
University:					
1 st Year Phil. n=60	80%	97%	100%	67%	75%
1 st Year Eng. n=98	61%	94%	93%	55%	69%
Second Year Biology N/A					
2 nd Year Th. n=12	83%	92%	100%	67%	75%
3 rd Year Th. n=10	80%	90%	100%	60%	70%

Although few believed that *ufiti* causes HIV/AIDS, more thought that it could cause *nyamakazi* (rheumatism) and, interestingly there was a significant positive response to the notion that *kukhwima* protects from witchcraft.

Taken as a group these responses contrast with the overtly western 'scientific' answers given in Tables 5.4.3.1(vii) (what causes illness), Table 20 (would you use fortification yourself?), and 22 (how do you prevent HIV/AIDS?), for example.

5.4 A survey of prevailing cultural practices in Malawi.

Section 5.4 is divided into two parts. The first section is derived from literature review; the second section reports my own findings.

5.4.1 *Literature review*

5.4.1.1 *A vibrant traditional medical practice*

This section briefly reviews the literature on culture relevant to the HIV/AIDS discourse.

Msonthi (1984 and 1986, 104 – 109) estimated that there were over 50,000 traditional practitioners in Malawi. While the psychic influence and utility of traditional medicine and *ufiti* discourse extends to most Malawians, many of whom use both traditional and western medicine, I consider Msonthi's estimate of 50,000 traditional practitioners too high for a Malawi population of 9.7 million, if Msonthi was referring to the professional (full time) traditional practitioners.²⁵⁵ Based on my research in Likoma, Malindi and Zomba municipality, I would estimate that the number of professional traditional practitioners approaches one practitioner per 2 thousand people (Cf. Peltzer, 1986: 73; Kapapa 1979: 1 – 4; Wilkinson et al., 1991: 223 – 225; Kafumba-Utonga, 1981: 63). This gives a total of about 5,000 professional traditional practitioners. This figure has to be compared to the 500 doctors in Malawi (Cf. Britannica data, 2002, Muula et al., 2001) and about 700 clinical officers and medical assistants.²⁵⁶

To this professional core must be added traditional birth attendants, semi-professional traditional practitioners and ordinary people with some herbal or other traditional medical skills, which they use on a part-time basis. Likoma, for example, despite the history of longstanding Christianity and western education, supports five professional traditional practitioners and at least the same number of non-professional traditional

²⁵⁵ I would assume that this was meant to be 5,000, giving a figure of 1 professional traditional practitioner for every 1900 people.

²⁵⁶ In Malawi, clinical officers and nurses do many of the tasks that would normally be performed by doctors in better-resourced western contexts.

practitioners (Kumpolota, personal interview, 18/7/00) on a small island of 8,074 inhabitants, suggesting a widespread use of their services. Likoma people, if only in their support of five *sing'angas*, a ratio more like that of British general practitioners to the British population (*Medeconomics*, 2001: 60), show signs of attachment to traditional medicine.²⁵⁷

This high use of *sing'angas* has also been noted from a western clinical perspective (Wilkinson et al, 1991) with patients using both western and traditional medicine. From a regional perspective it was noted at an HIV/AIDS seminar by Msiska (then an UNDP technical adviser on HIV in sub-Saharan Africa) that 'the emergency of HIV/AIDS has reduced the advantage of bio-medicine over traditional medicine to zero in many developing countries'.²⁵⁸ This thesis argues that this loss of advantage has been caused by the impotence of western medicine in developing countries to adequately tackle HIV/AIDS because of socio-economic and epistemological reasons.

In the context of HIV/AIDS, it is worth noting the abiding strengths of some localised traditions. *Nsondo* initiation rites are, for example, still very current in Mangochi (Munthali, 2000).²⁵⁹ Parents still send their children to these rites, which may involve physical sexual initiation of their children by *afisi* (surrogate sex instructors) (Munthali, 2000: 279 - 286). Another measurable aspect of abiding indigenous medical traditions is scarification (one mode of HIV spread in Malawi). Scarification, still a major therapeutic tool in traditional medicine, was, in a small survey, found to be useful in pain control (Gwilym et al., 2000).

Having noted some of these markers of an abiding tradition, we now turn to consider the wider issues of traditional medical theory. The particular theoretical framework considered here has resonances with the HIV/AIDS discourse.

²⁵⁷ Compared to four professional Traditional Mediciners Association of Malawi members in 1981 (Kafumba-Utonga). There is one general practitioner for every 1,856 (England), 1,695 (Wales), 1,425 (Scotland) and 1,670 (Northern Ireland) people in the United Kingdom.

²⁵⁸ Quoted by Njanji (1999) at <http://www.aegis.com/news/alp/1999/AF990956.html>

²⁵⁹ Cf. Johnston (1897: 410).

5.4.1.2 African Traditional Religion (ATR), *mdulo* and HIV/AIDS

The aim here is to revisit, with the benefit of recent work on the subject, the religio-cultural framework partly noted in Chapter Two, the issues of causality, and then to contrast their effectiveness with current religious attempts at instilling communal moral and sexual order, as exemplified by abstention, in the HIV/AIDS debate.

From the vantage point of the postcolony, we can critically revisit early colonial texts like MacKenzie's *The spirit-ridden Konde* in which, despite his obsessional concern with their 'spirits', he records the Nkhonde's differentiation of diseases caused by man from those caused by God:

If this disease has come from God, medicine will heal it; for God, who made us, made also the trees and gave us intelligence to know their properties. But if it has come from men, I cannot heal it (McKenzie, 1925: 273).

The quote is important for its tie-up of cause, disease, agency and cure. The Konde would have recognised the agency of man, the properties of medicines derived from trees and recognised illnesses from God (or nature).

Many colonial and postcolonial writers have emphasized the specificity of so-called 'culture specific African illnesses' (Cf. DeGabrielle, 1999:11). The concept of 'culture specific' illness would, from these observers and in the African context, ultimately, tend to reduce illness to the psychic level; i.e. break a taboo and you become ill. This tends to contrast with western 'culture specific illnesses' like those from smoking, drug and alcohol abuse subcultures, which produce physical illness. This term, culture specific, and the many treatises that emphasise the symbolic aspects of African medicine at the expense of the utilitarian functions of these, have during the colonial and postcolonial periods, served to distract attention from more important studies and analyses of African medicine. There was, for example, little exploration, in conjunction with chemists, of the efficacy of and the pharmacokinetics of African medicines. Many of the influential texts (Cf. Foster, 1976; Turner, 1967; Janzen, 1978) have contributed

to this ‘symbolic’ school of analysis.

Mdulo (sexual avoidance taboos): an example of a persisting communal framework of health

Literature searches also show attempts at classifying diseases in ways that, in their own terms, fail to encompass the received aetiologies of ‘African illness’. The split into Personalistic and Naturalistic medical systems (Foster and Anderson, 1978) has been driven by theory (Cf. Foster, 1976, Evan-Pritchard, 1937)), rather than research results (Cf. Johnsen, 1996). Personalistic causality ascribes illness to agency (God, host, ancestor, evil spirit or human being), while naturalistic causality ascribes it to an impersonal systematic model of disease resulting from an imbalance of natural elements of the body. As DeGabrielle finds when trying to apply the dual system to Malawi:

The dual classification as proposed by Foster and Anderson has its uses – but it does not quite fit the category of an African illness such as *mdulo* in a straightforward way; for all that I shall make use of it, but with qualifications (DeGabrielle, 1999: 12).

The *mdulo* concept, a specific relevant example of African Traditional Medico-Religious framework (Cf. Drake, 1976), has been, perhaps because of its symbolic value, the most studied of Malawi’s socio-medical traditions. Drake (1976) expanded on earlier work by Rangeley (1943), Schoffeleers (published 1979), and others. Later, Van Breugel (published 2001), Musopole (1984), Morris (1985), Chakanza (1987), and DeGabrielle (1999), and others have explored related themes and African Traditional Religion in general.

Drake (1976) studied the ‘folk aetiology, the practice of attributing causes of certain illnesses to breaches of social or sexual-conduct’ resulting in *mdulo*. She found that *mdulo* was more often a problem of nuclear family relationships ‘husbands, wives, parents and children, [...] exceptionally lineage relationships’. However the prevention of it involves the larger community. This is in line with both the settlement patterns of pre-colonial Malawi and the concept of public health framework we outlined in Chapter

Two. Drake (1976: 6) found that *mdulo*

is a component of the rites of passage since the prevention of it is a *raison d'être* of many ceremonies and the danger of its occurrence is a background feature with which most of them contend.

She further explained that *mdulo*

involves a more or less unified system of beliefs. The unity hinges on the concept of the misuse of reproductive functions, leading to debilitating illness or death. There is a relatively clear set of taboos and prescriptions designed to prevent the onset of illness and its progression to death. These taboos and prescriptions are related to things “set apart” and “forbidden” - sex and sexuality, blood and menstruation, procreation and death... Finally these beliefs and practices regarding sacred objects unite their adherents into one single moral community, whether or not we choose to call it a church’ (Drake 1976: 7)

Although Drake over-emphasises the kinship angle, it will be noted that her *mdulo* involves

- man-made taboos and prescriptions,
- beliefs,
- morality
- the power to cause death or birth and
- the inherent concept of blood and bodily fluids as contaminants.

Clearly Foster and Anderson’s personalistic and naturalistic concepts classification would fall short here. In *mdulo*, therefore, there is clear recognition of human agency, morality, religion, and chemical or other humoral factors as mediating mechanisms. This concept differs little from the western Christian concept that forbids premarital, or extra-marital sex. It also predates the secular concepts of avoiding casual or unprotected sex in which blood or bodily fluids are exchanged with resultant transmission of infection, whether gonorrhoea or HIV.

Many present day workers underplay the fact that transmission of disease was in the *mdulo* model also known to be mediated by bodily fluids. That the taboos extended the *mdulo* to provide a bolster to the moral abstinence rules should not have detracted from

the original association of act, transmitter and disease. One currently influential work on *mdulo* is that of DeGabrielle, which we will examine here. Although providing a useful analysis of *mdulo* from a theological perspective, DeGabrielle at times still seeks the overwrought and highly analytical conclusions of earlier anthropologists:

the effectiveness of a medical system to treat African illnesses should not be judged only on its biomedical results, but on what it claims to prevent, diagnose and heal, that is on its social values. I suspect that *mdulo* beliefs will survive – in a different form – even with more scientifically based knowledge, because science and “rationality” cannot stand what it stands for. The old, exterior forms will take on new meanings. The traditional African, as well as living in a symbolic world, is a realist, taking empirical evidence into account. The evidence points to a society in which everything is not as it should be (DeGabrielle, 1999: 22).

DeGabrielle here seems to equate modern science with rationality and ATR with symbolism. But as already noted, *mdulo* is not about mere lust; it is about breaking a taboo and the resultant social, medical and psychological sequelae. Despite taking a rather romantic view of *mdulo*, DeGabrielle is on firmer ground when he continues with the religious aspects:

As part of a system of religious beliefs, the *mdulo* complex expresses a people’s values and what they think the world should be like. I would like to present *mdulo* not as a superstition, but in fact a very humane complex, one which recognises human weakness and the need for social order, the consequences of human actions (i.e. that the innocent can suffer), moral responsibility for each other’s actions, and at the same time offers a route for atonement. There are many different orders/levels of understanding (emic), literal, and symbolic amongst the people. Some people act out of the fear of consequence, no matter what Mary Douglas says about the foundations of the belief systems of “primitive” religions (1999: 22-23).

This scenario could easily describe the situation in the early eighties when western science did not know the exact mode of HIV transmission. The health promotion prescriptions then, essentially ‘avoiding Haemophiliacs, Haitians, Homosexuals’ were an attempt at a social order that would contain an epidemic, a western *mdulo* taboo law. But DeGabrielle may be overstating the point when he continues:

Some people know that things do not *really* happen if they break such and such a taboo, yet they continue to observe things because of the elders and obedience to them. Nothing can stop people from committing adultery (not even Christianity!), but people need a way to impose some values and social order on their environment, as well as making a new start if they have made a mistake (1999: 22).

But it is an overstatement that vindicates the pre-colonial socio-medical framework. They too needed a moral and social health framework. Present day observance of these frameworks continue because, given the socio-economic framework dominated by poverty, they are still relevant and useful. In my own work, I found that although there is still much respect for elders, the observance of taboos is out belief or communal duty, rather than to please elders. In the urban areas, the new locations for *mdulo*, many cultural power brokers are not particularly elderly.

DeGabrielle concluded that '*mdulo* beliefs and ideas are constructed by society for the welfare of its fundamental unit – the lineage'. This requires a climate where there is obeying elders, a keeping of *miyambi* (customs), an ordering of sexual relations, a prohibition of pre-marital sex, a recognition that there are preferred and prohibited marriages, a set of incest laws, and an observance of these laws throughout life (DeGabriele, 1999: 20).

Having arrived at this useful point, however DeGabrielle muddies the field by resorting to Mary Douglas' concept of 'Purity and Danger' (Douglas, 1969: 4) where she asserts that in 'primitive religions' 'ideology is not patterned around fear but around dirt and order'. There seems to be a contradiction here, if the 'primitive people' have personalistic medical beliefs, then the 'dirt' should be out of the question. If Douglas' theory is to hold, then 'primitive people' must also have recognised the 'naturalistic' role of dirt.

In his review of the literature and in his own research findings, DeGabrielle, while recognising that *mdulo* is a 'very humane complex, one which recognises the need for social order, the consequences of human actions' and that it is a 'cultural tool' in a 'social' context, fails to identify a basic reason for the continuing appropriateness of *mdulo* – the socio-economic environment.

In the Malawian context, the *mdulo* complex, measured against the western health promotion concepts and their lack of socio-economic applicability, still makes as much sense as HIV naturalistic theory.

Nyau: a formative social construct

Another aspect of culture, looked at in Chapter Two, refers to the localisation of influential beliefs and practices. Mwale (1977, 152 - 157), from a self-confessed insiders point of view, discussed this localisation, and suggested that it was difficult for the uninitiated to get access to confidential *Nyau* information. Mwale argued that 'magic' (his term) is historically central to *gule wamkulu* (big dance) because of its communal and individually protective function. Although he did not elaborate on this 'magic', Mwale's work can be seen as noting the crucial influence among those rural, and later urban youths, and men who are initiated in its rites. This thesis, despite Mwale's inability to more clearly define this magic, views this 'magic', real or otherwise, as socially constructed taboos, which may be harnessed to resolve conflict in cases where secrecy, modernity and tradition conflict. This state of affairs is particularly acute where conflict, pertaining to resources is intense, whether in colonial or postcolonial periods. These *nyau* constructs are therefore, in their formative aspects, relevant to this work.

Causality revisited

Morris (1985: 14 - 43) in outlining Chewa concepts of disease divides these into several categories. First are those based on belief in nature or indirectly attributed to God. Second are those related to some moral or ritual infringements and are hence "social diseases". Third are those afflictions associated with either witchcraft (*ufiti*) or sorcery (*matsenga*); and, fourth, those associated with spirit entities such as *vimbuza* or *tsoka*. Again Morris' classification includes the 'naturalistic component' of diseases caused by nature. With respect to the second and third group of diseases, it is to be noted that these may require the agency of man and or chemicals. The Chewa were thus not

unaware of natural causes of illness.

These causes of illness give traditional practitioners cultural, medical and religious powers. Schoffeleers (1989: 172 - 173), building on work by Kibongi, (1969), Vilakazi, et al. (1986) and others, suggested that

in large parts of Black Africa the medicine-person or *ng'anga* provides a framework within which to conceptualise the person of Christ and the role of the Christian minister. This [conceptualisation provides] privileged access to African conceptions not only of Christ and the Christian ministry, but also of sin and redemption. This is so because the *ng'anga* is the person whose duty is to specify which moral trespasses have caused his client's suffering and what the latter has to do to free himself of that suffering.

Vilakazi et al (1986: 156) had stated that

all [African churches] are syncretic... All their Christian ideas are edited by the religious ideas they bring with them from their cultural upbringing.

Can the same be applied to African conceptions of western medicine? This work suggests that it can. There is a level at which a society that is dependent on traditional medicine will filter many medical notions through that traditional prism. This is particularly the case if those traditional values are combined with, as we have noted, the paucity and unavailability of the western medical alternative. The HIV/AIDS epidemic has to be seen against a background of people living lives given context by the limitations or otherwise of the socio-economy. Their life experiences, rather than aspirations, make the cultures appropriate. The cultural power brokers, who are the interpreters of social and sexual norms, as in pre-colonial times, negotiate space, legitimacy and authority (and in the end cooperate and compromise) with the economic power brokers.²⁶⁰

HIV/AIDS is like *mdulo* in being associated with transgressing sexual rules, precautions and regulations. It is also, for innocent victims, misfortune. Further, it is

²⁶⁰ This may explain the corruptibility of some norms.

like smallpox, an epidemic. It is for these reasons an ideal space for the contests of power between traditionalists and reformers, western medicine and traditional medicine, between ATR on the one hand and Christianity and Islam on the other, and between those who debate aspects of indigenous gender, sex and morality. This is relevant when we consider that, as Tembo et al. (1993: 47) claim

Heterosexual cultural practices are at the heart of life of Malawians. These practices are deep rooted in our culture. They encourage sex with multiple partners, making many people most vulnerable to HIV/AIDS.

This sweeping statement requires clarification. The heterosexual cultural practices in traditional culture are, as we have seen from the various taboos, specified and constrained by taboos. They are not therefore 'wanton' in the Caldwell (1989) sense. But in the hybridity and duality of school-going Malawian culture, they are also subject to corruption by socio-economic forces. Mbembe's (2001: 7) observations on the role of sex in postcolonial Africa, in terms of social and political power, recreation and economic agency, are relevant here. These heterosexual practices are also intimately connected to the value of children (McAuliffe, 1994), particularly among males. The reluctance to use condoms, for example, may be related to both the value of children as well as the 'pleasure' aspect. Kondowe et al (1999: 12) reported that:

Cultural views about sex are such that [unprotected] sex is seen as the greatest drive for marriage. It is a very important social factor and is more for procreation and personal gratification than for love. It is considered natural and unavoidable, particularly for men such that manhood without sex is considered incomplete. It also serves many rituals such as initiation rites, death rites, (a widowed woman is made to have sex as a cleansing ritual before burial of the dead husband and after burial) and various magical rituals.

However these are set within a framework of rules and taboos, rules and taboos that decide what is communally moral. The power aspects of sex are demonstrated by the situational homosexuality pervading Malawian prisons. Here older inmates abuse young inmates both for sexual gratification, because the children are poor and powerless and as part of a pecking order.²⁶¹

²⁶¹ See for example <http://www.aegis.com/news/bar/2001/BR10120.html>

The concept of a moral community and the observance and avoidance of sexual taboos has to be contrasted with the postcolonial secular and religious attempts at imposing sexual abstinence in an attempt to prevent HIV/AIDS. In terms of outcomes there may be no contradictions. From this model, we can predict that HIV/AIDS shortens child spacing periods rather than causes abstinence. Inadequately explained attempts at imposing sexual abstinence in the presence of increased death runs counter to the traditional survival ethos: the more the deaths, the more children are required. The abstinence of *mdulo* and *tsempho* were related to child spacing rather than population depletion. *Mdulo* and other related traditional concepts controlled sexuality without constraining reproduction. In the present context of desperate poverty, high infant mortality, malnutrition and poor medical services, communities will see HIV/AIDS in *mtundu watha* (the family/clan/tribe is becoming extinct) terms; an imperative that leads to the need for more children in the hope that some will survive.

When local communities recognise HIV/AIDS in terms more suited to their socio-economic circumstances, this may bring them into epistemological conflict with forces of modernity.

Foster (1995), for example, found that in the Zomba area some people were uncertain as to the identity of AIDS: seeing it as TB, *kanyela* or as 'propaganda'. In Zambia, Yamba (1996: 200) found that scientific messages could be 'wiped out' by traditional healers because they did not fit in with traditional beliefs.

It could be argued that those who saw HIV/AIDS as *kanyela* were, paradoxically, from a communal public health perspective, justified. This point of convergence with western health should have been exploited for HIV/AIDS prevention.

and <http://www.stoptorture.org/steps/malawibody.htm> where it is reported that Zomba Central Prison had 180 child offenders (those under 18 years of age) in 1998 (Amnesty International figures).

5.4.1.3 Tradition, class, education and modernity

With respect to the ‘culture of heterosexuality’ noted above, King and King (2000: 76 – 84) painted a bleak and pessimistic outlook of communal behaviour among knowledgeable Malawians. They recorded high-risk sexual behaviour leading to deaths of ‘civil servants, professors, lecturers, hospital staff, lawyers, teachers, businessmen, engineers... as well as Europeans and Asians (ibid: 177: 78)’, people, in their view, who should have known better about HIV/AIDS. But King and King failed to note the socio-political background and power dynamics; their assumption appeared to be that education had failed to overcome cultural forces. Yet King and King’s despair can be seen to arise from the politico-economic exploitative excesses of the rich, rather than a failure of education. Hence the finding that ‘high socio-economic status is, [among women] in Malawi, a risk factor for HIV-1 infection’ (Dallabetta, et al 1991) due to infections acquired from their husbands, and the latter’s mistresses. This class aspect of sexuality is, perhaps, not a simple manifestation of Caldwell’s (1989) ‘wanton sexuality’, but rather the ability of elites, using money and power, to extend and corrupt existing boundaries of the already liberal sexual norms.²⁶²

In this regard we have already noted that the related political mass rally culture of the Banda era and its sexual abuse of women *mbumba* dancers (Mkamanga, 2000; UNIMA, 1997), as well as the “seminar culture” that survived the Banda era.²⁶³

This exploitation of women is part of the gender inequality to which we now turn.

²⁶² Some men justify this on the grounds of tradition. ‘Tradition’ is held to entitle them to second wives or mistresses.

²⁶³ The ‘seminar culture’ results from the many donors or government funded meetings and seminars at hotels or resorts, where, because of the money, sex workers and exploited junior female staff may abound.

5.4.1.4 The role of gender.

In reviewing cultural literature relevant to HIV/AIDS, the weak role and low status of women are common findings (Cf. Phiri, I., 1997; UNIMA, 1997; Mkamanga, 2000) in the postcolony. This status is in keeping with the role women had, their religious roles excepted (Phiri, I., 1997: 23 - 42), pre-colonially and during the colonial era. This historically low status of women extends to sexual power in family planning where women may not be able to make major decisions on their own, requiring the consent of their husbands or partners, and sometimes, key extended family members to approve their use of contraception (MNFPS, 1994: 3; and Cf. Palamuleni, 1998).

HIV/AIDS also imposes a big burden on widows and female orphans, making them more susceptible to further economic and sexual exploitation (Cf. Akeroyd, 1996: 42; UNIMA/SARDC, 1997: 29).

However, within this weak status of women there is an internal dynamic that further predisposes women to HIV/AIDS.

This dynamic can only be explained by noting that the roles and powers of some women over their peers in organising initiation rites, in certain aspects of rites of passage arrangements, and within female environments remain strong. In earlier post-colonial discourse, much was made of elites and urbanites 'improving or westernising' traditional practices (Cf. Chisiza, 1961). However, a much stronger case, as Kamlongera's (1998: 17 - 24) study shows, can be made of some traditional practices transferring to urban sites, using contemporary materials and contexts but retaining the formative and gender inequalising roles. This transfer is necessary, given that urban women and their rural relatives have to have common means of communication and socialisation despite their unequal socio-economic statuses. Given the economic disparity, intermittent social events serve these purposes quite well. Elite women, for example, have themselves re-invented a form of *chinamwali* (a mixture of the debut of an engaged woman and hen party), the "kitchen party". Kamlongera (1998) considers this as a deliberate attempt to satisfy both Christian belief and an indigenous initiation

rite, a typical Malawian post-independence quest for returning to the country's cultural roots.

These processes transfer *anankungwi* (initiation rite counsellors) powers to urban environments and also uncritically bolster the powers of rural *anankungwi* (who may be involved). While the rituals of the new ceremonies fulfil the needs of urban women and, by travel, acknowledge an ontological shift, not all epistemological differences between the new urban *anankungwi* and the rural *anankungwi* are addressed. The resurgence of these rural rites in urban areas, by emphasising the *zakumpanda* (women's affairs) aspect, may erode some of the gender empowerment achieved by educated urban women. Gender empowerment, as previously noted, is important in HIV/AIDS prevention. In seeking compromises between rurality and urbanity, if not between tradition and modernity, without resolving the contradictions, women may perpetuate practices conducive to HIV/AIDS spread.²⁶⁴

5.4.1.5 Family Planning

A review of family planning literature contained misconceptions that reflected this weakened role of women and the role and value of sex in recreational activities in Malawi. For example, in most surveys:

- Despite the high awareness/knowledge of fertility regulation (96 per cent among women, 99 per cent among men), in actual practice research data shows that, by 1996, only 14 per cent of married women had used any western family planning methods (Malawi MKAPHS, 1996: xi). And despite their high knowledge only 24 per cent of women and 43 per cent of men had (ibid, 1996) used condoms in their last casual sexual contact, even though 71 per cent of females and 89 per cent of men knew where to get the condoms (ibid, 1996). The survey does not indicate if the condoms would have been available, a subject we examine in Chapter Six.

²⁶⁴ These ceremonies involve discourse, dancing, communal cooking, and other activities, appropriate to rites of passage.

- The MDHS (2000) data showed that about 97 percent of all women in Malawi knew of a modern method of family planning compared to only 66 percent who only knew of a traditional (indigenous) method. However, despite this, almost universal, knowledge of western family planning methods in Malawi, by 2000, only about 25 percent of all women and 31 percent of all currently married women used such modern family planning methods.²⁶⁵
- Figures for 2000 indicate that only 5 percent of women and 14 percent of men who had sexual intercourse during the 12-month period prior to the survey used a condom during their last sexual meeting with any partner. In this minority who used condoms, the use of condoms was more prevalent during sexual intercourse with non-cohabiting partners than with their spouses (Malawi MHDS, 2000). Within marriage only 2% of couples use condoms (Malawi National Statistical Office, 2000b).²⁶⁶
- As previously stated, 21% of marriages in Malawi, a decade after the arrival of HIV/AIDS, were polygamous (Malawi MDHS, 1992).²⁶⁷
- Men freely stated that they should have the final say in the choice and use of contraception (Kornfield and Namate, 1997).
- Women expressed fears about the accumulation of the pill in the body and also a fear of condoms lodging in the vagina (Tavrow, 1994).
- Men stated that they regard having sex using condoms as ‘eating sweets with wrapping paper on’, an attitude that puts some men off condoms (Kornfield et al, 1994; Jimmy-Gama, 1999). It was also commonly stated that condoms take away sexual pleasure. This expressed belief, in its agency in promoting unprotected sex, sometimes overrides the men’s scientific knowledge of HIV (Bandawe, 1992).
- Young men expressed beliefs that one could tell, from their body weight if a woman was HIV positive or not. (Tavrow, 1994). If fat, they are perceived as unlikely to carry HIV.

²⁶⁵ Such as condoms, the rhythm method (‘natural family planning), withdrawal, and the use of pills.

²⁶⁶ The MDHS 2000, a national-level sample survey provides information on demographic trends and other indicators of maternal and child health in Malawi. It also provides up-to-date information on fertility, childhood mortality, marriage, fertility preferences, awareness and use of family planning methods, infant nutrition, maternal and child health, maternal mortality and HIV/AIDS.

²⁶⁷ Only 12 – 15% of Malawians are Muslims. Thus all polygamy is not solely due to Muslims.

However, even if people were willing to use condoms, the availability is, according to USAID figures, less than 5 condoms per man per year in Sub-Saharan Africa (Shelton et al., 2001: 139)

Thus we note that even though family planning agencies are actively disseminating information there is still a big gap between the various factors: knowledge, understanding, misconception, need, availability, gender issues and affordability. Some of these misconceptions could be blamed on cultural factors.

5.4.1.6 Non-indigenous religions

The role of Christianity, Islam and other religions in affecting the actions of their adherents can be ambiguous. Religious activities, particularly activities geared to the youth, such as gospel singing and community work, while offering solidarity and an aspirational background may, given the context, fail to immunise adherents from the full vicissitudes and economic realities of life.²⁶⁸ In some cases conflict will arise over aspects of traditional rites of passage.

Some 'born again' church activities seek to create alternative social structures. However, ultimately these social structures are subject to political and economic constraints in Malawi (Cf. van Dijk, 1998). Some new churches have tried to emphasise the compatibility of the Christian and indigenous ideals (Foster, 1999, and 2000). The Last Church of Christ, for example, aimed 'at promotion of the ideal of harmony between Christian and indigenous values, Christianity not mediated by Western values and institutions' (Foster, 2000), perhaps an extreme example but one reflective of the duality of large tracts of Christianity and Islam in Malawi.

In a number of cases however these noble ideals are subverted by the economic realities, with a number of 'born-again' religious groups highly dependent on foreign

²⁶⁸ These realities include the need for employment and housing, as well as economic obligations to their extended families.

donor money for their activities and survival as groups (Cf. Kornfield, 1993: 1).²⁶⁹ Thus the success of these new churches can in the short term only depend on foreign money to 'westernise' the adherents. These 'born-again' movements may therefore merely increase the aspirational quotient of life among their adherents. When conflicts arise between these aspirations and reality for socio-economic reasons, the pragmatic path of the traditional is usually the only alternative.

On a broader front we have, in Chapter Four, noted the current debates between the Churches and others on the HIV/AIDS epidemic (Schoffeleers, 1999). The churches continue to promote abstinence. Many Malawian Muslims have, partly because of their tradition of polygamy, and, as noted in Chapter Two (Cf. Ng'ombe and Mawaya, 1997: 7 – 9), taken a more pragmatic view on condoms.²⁷⁰ However the Malawi Sunni Muslims Supreme Council, in a document that critiqued President Muluzi's personal probity and national governance, objected to his promotion of, among other things, 'the use of alcohol', corruption and misuse of government money while the poor suffered, breaking Ramadan rules in 1996 –1997, encouraging women to dress scantily, and permitting and facilitating the use of condoms via *Banja la Mtsogolo* Clinics. These allegations suggested that Malawi Sunni Muslims did object to the liberal use of condoms.²⁷¹ The Malawi Sunni Muslims' disapproval of *Banja la Mtsogolo* activities contrasts with those of Senegalese and Ugandan Muslims (where rules have been adopted to allow condom use) and South African Cape coast Muslims (where contraception is allowed, including the use of condoms within marriage especially where one partner is HIV-positive).

The objections of the Malawi Sunni suggest that political considerations have hardened the attitudes of some Muslims in Malawi, producing a swing towards conservative

²⁶⁹ I have, in my archives, a number of letters from Christian groups in Malawi soliciting funds from abroad. See also the extraversion discourse by Bayart (1993) and Chabal et al. (2001)

²⁷⁰ Their practice of male circumcision has also been found to give a degree of protection from HIV/AIDS.

²⁷¹ The Sunni Muslim attack on Muluzi has internal intra-Islamic contests as well as wider political concerns. See http://www.afrol.com/countries/Malawi/documents/Sunni_Council_Muluzi.htm and also at www.geocities.com/nda_mw/march5.html.

Kanyongolo and Chirwa (2001) offer a severe contemporaneous critique of the Muluzi administration. For the international donors perspective of the Muluzi administration's monetary spending see <http://allafrica.com/stories/printable/200203260564>.

interpretations of the Koran.²⁷²

Given the strength of the heterosexual indigenous culture which permits, within certain contexts, multiple sexual partnerships, the promotion of a simple concept of abstinence (excluding other accompanying initiatives) by religious leaders for most of the last 15 years could arguably be seen as a negative factor in the context of HIV/AIDS prevention, given the power of some localised taboos.

We would therefore argue that these religious and cultural debates have been factors producing ambiguity and promoting duality in the HIV/AIDS debates.

5.4.1.7 The value of life and fatalism

One dimension of the HIV/AIDS epidemic that has not been widely explored is the corrosive effect on the value of life of the many AIDS deaths. This is intimately related to the discourse on poverty and the particularly large gap between the rich and the poor in Malawi. One of the often unspoken subjects in Malawi is that of the respective values of the lives of the rich versus the poor. While death is an equaliser in all Malawian cultures, in life the hierarchical construct between elders and the young is mirrored by the disparity in the quality of rich and poor lives. This difference in the quality of life between classes is the successor to the debates about the respective values of European and African lives. The African elite are now the *bwanas*²⁷³ in charge of both local resources and the means of accessing foreign resources. In the case of the HIV/AIDS discourse, the elites are also responsible for prioritising national expenditure.

Further, in the contexts of HIV/AIDS, a number of commentators have previously interpreted the 'high risk' behaviour of youth as 'fatalism' (Forster, 1998) or 'macho high risk behaviour' (McAuliffe, 1994). Some of the factors which drives these fatalistic attitudes include: the poverty, the inferior status and the lack of real

²⁷² Details of Muslim attitudes in some parts of Africa are available at <http://allafrica.com/stories/20010/090178.html>;

<http://www.aegis.com/news/dmg/2001/MG010704.html>; and <http://www.mjc.org.za/secretariat/AIDS>.

²⁷³ A term of respect once reserved for European colonial masters.

alternatives accorded to peasants in colonial and postcolonial Malawi, the absence of employment and job prospects, the limited medical facilities and other factors which make *anthu wamba* (peasants, ordinary people) lives expendable (World Bank, 1995: 1 – 43). HIV/AIDS has merely exaggerated and focused an already present problem. Saidi (1999: 43) noted:

Secondly, the plight of AIDS has also created a negative conception of the value of human life. Even in the threat of death in its consequences as far as AIDS is concerned, sexual immorality does not scare people as being a ticket to contracting HIV. Prostitution [...] those in positions of power and influence take advantage of the other [...] Some bosses demand sexual favours before a woman's application for a job is accepted... In such situations human life with its potential becomes something that can be sacrificed for money, job opportunities and material comfortable (sic) life.

Given that the elites are, by and large, able to afford preventive and curative services, HIV/AIDS can be seen to have exacerbated both the economic gap and the differences in life worth. HIV/AIDS awareness messages targeted at these groups need to be sensitive to these factors. How these awareness messages are expressed is also important.

I now contrast these literature review findings with my own findings.

5.4.2 Fieldwork findings

5.4.2.1 A vibrant cultural tradition

I observed that the strength of cultural traditions is evident in, and reinforced by, popular cultural dances. I observed these dances during my two field trips, both at the formal state and on district occasions, as well as in traditional settings. These dances reflect various cultural activities,²⁷⁴ such as rites of passage (*chinamwali*), weddings (*chioda, malipenga*), social norms (*chintali*), religion, entertainment (*minoghe*), politics and social comment (*ingoma, beni*), response to colonialism/social comment

²⁷⁴ I am grateful to McDonald Maluwaya, Choreographer, Kwacha National Dance Troupe, for notes on the functions of and the forms of various traditional dances, which the troupe performs.

(*mganda, beni*), and comedy.²⁷⁵ The role of [comedic] praise singers or oral poets, in its self-deprecatory but potent mode is used to prick the pomposity of the elders in a hierarchical culture as well as defining the boundaries of acceptable cultural behaviour.²⁷⁶ Comedians and praise singers have been known to criticise, albeit gently, even Dr Banda.²⁷⁷ In the multi-party era, comedians and dramatists have sometimes set the socio-political agenda.²⁷⁸ And many official drama presentations have used comedy and drama to promote AIDS awareness messages. However, most of the urban and rural drama groups have utilised the ‘abstention and condom’ model of HIV/AIDS awareness (Cf. Chimombo, 1998: 36 – 37). Contextual cultural issues like *chokolo* (widow inheritance) and polygamy have not been adequately tackled. It was also interesting to note that while some drama groups, like *Kwathu*, under Dunduzu Chisiza Jr, tackled political issues there has been little direct exploration of the issues of poverty. Poverty is usually shown as a constant in the background: the ragged clothes, the hungry look or malnourished children, but rarely voiced.²⁷⁹

In attempting to clarify the role of tradition on HIV/AIDS I sought to investigate if the oft-stated strength of the hierarchical Malawi society in which respect for elders is paramount (Forster, 1994: 477 - 479; Phiri, K., 2000: 12), still existed. In personal interviews, I found that a significant terrain of contemporary culture of Malawi is one where personal submission, at least in public, to cultural authority figures: clan leaders, *nankungwis* (initiation rites guardians) (Cf. Kamlongera, 1998) and others, like *sing’angas*, were the norm, rather than the exception (Cf. Forster). However, the reverence for authority – and implied knowledge - is mixed with a post-Banda irreverence for authority (Cf. Phiri, K., 2000).

²⁷⁵ As some of the traditional dances are derived or are part of continuing rites of passage rituals they can be sexually explicit. Even the neo-traditional *Minoghe*, for example, features highly stylised choreography of sexually explicit courting behaviour.

²⁷⁶ Praise singers are allowed, within the context of the hierarchical African systems, to criticise chiefs and other powerful figures in the context of praise. In contemporary Malawi, comedians like Jacob and Izeki have been influential in shaping public attitudes towards those with disabilities, HIV/AIDS, community development, privatisation, gender and other issues.

²⁷⁷ An *ingoma* dancer used to ‘challenge’ Banda to join the dance at state occasions.

²⁷⁸ See for example, Eric Mabedi and Joseph Nyanga *Jakobu and Izeki*, Cassettes Volumes 1 – 3, Blantyre, Malawi.

²⁷⁹ Possibly a legacy of Banda’s strict censorship.

Traditional practitioners

The popularity and wide use of traditional practitioners is evident at a personal (and communal) level. They are found at all markets, trading centres and posts, as well as the traditional village sites. The traditional practitioner is perceived as being able to offer a comprehensive range of diagnostic and therapeutic services, a perception confirmed by traditional practitioners themselves. Kumpolota (Personal interview, 18/7/00) stated that he still treats ‘diseases that arise from *masalamusi* (witchcraft), like madness, infertility, malaria, *nyamakazi*, as well as sexually transmitted diseases like *chiwerewere* (diseases from promiscuity – syphilis), *chindoko* or *chizonono* (gonorrhoea), *chipata*, and genital ulcers’. Adini (Personal Interview, 10/7/00) made a similar claim.

At Likoma, Mzuzu, Lilongwe, Machinjiri (Blantyre), traditional practitioners are to be easily found in all locations, villages and markets. In Likoma, Malindi and Zomba I observed widespread use of traditional practitioners. When I visited them, both Adini and Kumpolota had people of school age, some apparent victims of *chamba* (marijuana) abuse. All three, Adini, Matimati and Kumpolota, claimed to be able to help those with AIDS-related wasting if they came at an early stage of their illness. Kumpolota admitted he could not cure AIDS but merely helped the wasting stage. Adini and Matimati’s claims, particularly the latter, were less credible.

Even among the highly educated and ‘westernised’ a role for traditional medicine was usually conceded. One of my adult interviewees, Mr Mwase, a retired civil servant “steeped in Shakespeare”, although seeing no role for the treatment of HIV by traditional healers, was willing to concede a role for them in the treatment of *nyamakazi* (rheumatism).

During my fieldwork I observed that many young Malawians continue to show scarification marks, particularly on the chest and usually the covered parts of the upper

and lower limbs.²⁸⁰ Few Malawians now scarify the face. I confirmed that the use of scarification for vaccination, fortification and treatment is still common.

Daily discourse

I noted that in daily discourse, there are frequent references to *mwambo wathu* (our culture), *malinga ndi za kwathu kuno* (according to our norms here), *uko ndiye kulakwa* (that is culturally wrong) and other expressions. These normative expressions seek to define cultural boundaries that are supposed to be known by most people. Some of these norms of behaviour can be identified in times of communal problems. Among the Yao and Nyanja of Malindi, for example, every one is expected, following a death, to virtually drop everything and attend the funeral process. Death, like illness, is viewed as a communal, rather than family, affair; in HIV/AIDS discourse it is an asset worth exploiting. Malindi people expressed unanimous surprise that someone could even contemplate not attending a funeral. Those that do not attend funerals are viewed as selfish, uncaring or, even, *afiti*. This construct provides a form of social welfare that enables the poor to afford funeral costs. Similarly, on the MBC, *Nkhani za m'maboma* (Tape Two, 28/6/2000) had a story of a chief who had imposed a fine of a chicken each on youths in his area for refusing to attend their relative's funeral. Cultural norms dictate that attending funerals is the expected behaviour.²⁸¹

Similarly, sudden unexpected illness may lead to clan or village elders discussing the possibility of *matsenga/ufiti* (sorcery/witchcraft). Interestingly, *ufiti* discourse, of which more later (See 5.5 and 5.6), is resorted to by educated communal leaders like retired teachers, medical assistants and others, people who must be, for example, aware of the 'scientific' causes of HIV.

Other expressed oral attitudes, which I recorded, often took the form of statements and epithets describing beliefs, problems and experiences from a personal and communal standpoint. These statements often reflect personal and communal beliefs, as well as

²⁸⁰ Usually observed during physically demanding work requiring removal of upper garments, such as roadwork, pulling in fishnets and in the construction industry.

²⁸¹ Cf. Rangeley (2000: 56) for attitudes among the Chewa during the colonial period.

reflecting strategies for coping with different problems. Interesting perspectives of attitudes to HIV/AIDS can therefore be gauged from these statements. For example: *mabvuto saatha* (problems never end)²⁸² can be a positively formative command, by exhorting some perseverance. *Mtundu watha* (the clan/tribe is finished), *anthufe tinalodzedwa kale* (we are already/born cursed), *abale mwatilodza* (my relatives, you have bewitched me) and *edzi ndi ufiti* (AIDS is witchcraft) sound and appear fatalistic. However, I consider that statements like *Edzi ndi ufiti* and *Edzi inabwelera anthu osati nyama* (AIDS was invented for humans, not animals) suggest, not necessarily as previously reported by other observers, a causality perspective but a pragmatic construction of reality, which may appear fatalistic. The attribution of misfortune to *ufiti* thus enables people to cope with the reality of poverty and powerlessness in the face of disease. The recognition that 'AIDS was invented for humans, not animals', given the '*matenda a boma*' (the government disease) construction, suggests an awareness of inadequate government attempts to alleviate this suffering. This daily discourse therefore has aspects, which, like some localised practices, interrogate prevailing governance in ways that minimise conflict with it. These coping, discursive and interrogative strategies and constructions recruit and or engage in the historical *ufiti* discourses.

Thus for example the observed discourses of *wonenepa sadwala* (the fat/healthy looking one is never ill) involve the use of pre-colonial phenotypic and phenomenological evaluations of traditional medicine. Famine survivors were those who were fat or healthily built at its onset. Around these observations have arisen a whole set of taboos about, for example, calling someone's child 'fat' (the caller may be accused of at best wishing the child bad luck or being *m'fiti*). In 2002, complimenting an indigenous Malawian on weight loss (a common event from malnutrition, HIV/AIDS and other diseases), may be fraught with danger: are you reminding them they have a wasting disease, being 'western' or indulging in threatening *ufiti* discourse? Viewed from this perspective, it is easy to see the connections between current *ufiti* discourse and its pre-colonial antecedents.

²⁸² Often said during funerals and in times of trouble.

Some observers, who perhaps ignore its discursive, interrogative and coping uses, have called this use of *ufiti* discourse communal denial. There is a degree of denial, but perhaps this denial is at state level, at the level of decision and resource allocators. Challenging this construct at an individual level is difficult for the same reasons. As the students' responses will show, knowledge without the means to utilise it, 'book knowledge' as Chinua Achebe (1960: 64 – 45) put it, leads to impotence and paralysis.

We argue that references to the end of clans (*tikutha*), the use of phenomenology, the constructions that AIDS is witchcraft, suggest an explanatory process continuous with pre-colonial disease management frameworks and some causality concepts.

5.4.2.2 African Traditional Religion, *mdulo*²⁸³ and AIDS

I observed that when the western concept of AIDS causation is adopted, the patient becomes stigmatised as someone who wantonly sought his own destruction. The other modes of spread - blood transfusions, infected hospital or traditional practitioner instruments and other alternatives - are often ignored. Thus an AIDS victim becomes his own killer. At Malindi and Likoma the concepts of *mdulo*, *tsempho* (sexual avoidance taboos) or *kanyela* (disease following forbidden sex with a menstruating woman) as illness brought on by the agency of others persist. It was noticeable that when *ufiti* is adopted as explanatory it may absolve the family and the patient of responsibility for acquiring the disease. The concepts of *mdulo* predate HIV/AIDS, and their existence cannot be denied without offering alternative explanations.²⁸⁴ Traditional practitioners, like Kumpolota, have exploited the *mdulo* and *kanyela* concepts to offer alternative explanations for HIV/AIDS, explanations which find resonance among people who have no practical alternative. It will be shown (5.6) that the state, as system of governance and resource allocator, has also attempted to construct a similar alibi in the HIV/AIDS discourse.

²⁸³ A system of beliefs and practices guiding the care of children and sexual relations among adults, transgression of which can lead to *mdulo* diseases.

²⁸⁴ Some have offered malnutrition and other wasting diseases like TB as causes. However the increasing disjunction between HIV positivity and AIDS has resurrected the debate between malnutrition and other wasting diseases on one hand and HIV positivity on the other (Cf. *BMJ*, 2002, 324: 237).

5.4.2.3 Traditions, class, education and modernity

I observed that class was a descriptor that permitted people to move in and out of the observance of traditional practices. Some elites, when opportune, often appeal to the traditional values of *mwambo wathu* (our culture), this appeal often being a tool of non-observance of the same culture. I observed that economic power often enabled some men and, less often, women to break the heterosexual cultural rules and engage in sexual activity not sanctioned by these norms. I found that, among politicians, senior professionals, academics, businessmen and other elites, the possession of, often multiple, mistresses and lovers, was a widespread phenomenon. I found that allegations, some proven, concerning specific politicians, of incestuous sexual behaviour or indulging in under-age sex in the quest for power, were made by some informants.²⁸⁵ These practices were, according to my informants, often associated with the process of achieving political fortification (*kukhwima*).

These urban quests for a 'return to cultural roots' are also reflected in some communal behaviour seen in village and national locations, including the formal state ceremonies. Both national and local occasions must be viewed at several multi-faceted levels, some political, some economic, others socio-medical and yet others cultural; all seek the maintenance of order, not necessarily by re-invention (Hobsbawm and Ranger, 1983), but by restoration and re-appropriation. For example, the façade appropriated and set by Banda from "Chewa" traditions has not changed. The independence-day celebrations I observed, in 2000 and 2001, were, apart from the disappearance of the MYP paramilitaries from the stadium, similar to those of 1970. The format was similar: prayers, public events, including *mbumba* dances and rural traditional dances, the Malawi Police and Army parades, the presidential speech and then the football match. There were variations on a theme. In 2000 and 2001 the presidential speech came before the entertainment.²⁸⁶ Thus despite the modernity, the HIV awareness posters and the few AIDS awareness songs, added to the repertoire, the independence celebrations

²⁸⁵ Two highly educated professionals, for example, became subjects of these allegations, on attaining political office (Cf. *The New Vision*, 1, 3, 6th February 1997, page 1).

²⁸⁶ In the post-Banda era, people are free to leave before the President's speech.

were still dominated by traditional dances and images.

These celebrations, as in Banda's period, still serve to ritualise state power and 'traditionalise society' in ways that make modern concepts of civil society hard to sustain.²⁸⁷ The ritualised state power thus speaks directly to the rural areas in ways understandable and acceptable to them, while simultaneously asserting state power by military and police displays. This is because, as constructed by the state politicians, these rituals also make sense of the socio-economic context. The socio-economic substrate that resonates with traditional rural values is that where the elders and chiefs have legitimacy, one that also gives them power over shared communal resources.

But when these traditional concepts are transferred to the state, the elders become the *achikulire*, the neo-patrimonial politicians who control the patronage system. This control of the patronage system does not resonate with multi-party participatory democracy. In 2000 and 2001, I found that despite the multiparty dispensation, the underlying theme in the traditional dances, as under Banda, was of a praise nature designed to build up the image and status of the multi-party president, Bakili Muluzi. He was referred to as *tate wa dziko* (father of the nation) or *mtunda* (the highest authority).²⁸⁸ These discernible post-Banda formative elements confirmed Mapanje's (1995: 14) contention that 'de-autocratisation', of the political culture, had yet to take place in Malawi. Despite the multi-party dispensation, the potential politico-cultural dualities were still being formatted into a single official duality, *anthu akunja ndi ife aMalawi*, ('foreigners and us'). This is a duality that seeks to maintain internal order by minimising differences. Thus the state assumes the characteristics of a village, where differences are resolved, not through different parties, but at village council meetings.

This *akunja ndi ife* cultural duality of Malawi was shown to devastating effect when at one point the President intervened to 'clarify his views on national unity' after a group

²⁸⁷ Partly by undermining civil society and organisations that promote human and civil rights.

²⁸⁸ *Kumtunda* (lit. at the high point) carries the same connotation as *bwana mkubwa* (governor or ultimate authority) in its father of the nation sense. The epithet *kumtunda* has subtle meanings in the indigenous sense. It implies 'one who has gone far' in authority, achievement or, here by implication, fortification. A man therefore with whom one should not trifle. In the Afro-American colloquial language it equates to 'one on another level' or 'that guy is something else'. In all senses it attempts to imbue Muluzi with the same powers as Banda's *ngwazi*. In the concrete sense: Sanjika, the Presidential Palace, is located on top of Sanjika Hill.

of women from Nsanje had, during a deliciously delicate song and dance, heaped rude and ribald one-party era type insults on the opposition leader Gwanda Chakuamba. Until the President spoke, most of the Asian, European and American donors and diplomats must have, as in Banda times, been blissfully unaware of these negative images and sounds on a day of supposed national reconciliation.²⁸⁹ Here the duality was symbolised by the English language. Those speeches in the vernacular languages were for domestic consumption and those in English were for donors and foreigners.²⁹⁰

But it was not until I had left the stadium early - just before the football match - that the impact of the stage management of national unity and order struck me. Outside the stadium none of this carefully constructed, for the benefit of radio, television and donors, order existed. Groups of ill disciplined peri-urban *anthu wamba* (working class) youths with no tickets to get them into the stadium were rioting and being controlled with tear gas and rubber bullets.²⁹¹ As I had been, most of those in the stadium, least of all the donors, were blissfully unaware that the Police Mobile Force (PMF) was tear-gassing youths.

Thus the differences between 2001 and the Banda era were minimal but interesting. The marginalized youths, who follow no cultural or political strictures were, at least now, free to taunt and insult the PMF, without being viciously put down. This graphic dissent of the marginalized poor reflected how the new multi-party dispensation has constructed a universal control based on wider patronage with vertical loyalty to those *achikulire* with money and minimal force, in contrast to Banda's use of minimal patronage and maximum visible force for the dissenters. This new construct excludes most rural and urban youth. An attempt to extend patronage to would-be youth entrepreneurs was only marginally successful, since most of the loans ended up with the existing small traders because of the lack of business experience of the target

²⁸⁹ The president's intervention came after the women had finished their performance and appears to have been motivated by 'the donors' curious requests for translations. The curiosity had been prompted by the massive laughter of the stadium audience. That the donors were, perhaps, noting this phenomenon is shown by the withdrawal of Danish AID in January 2002. The Danes cited 'negative political developments' and misuse of funds (Tenthani, R. BBC African Service News 3/2/02).

²⁹⁰ English or French facilitate political dualities where 'multi-party governments' can function as ostensibly democratic to foreign observers when they are essentially functioning almost as hegemonic single-party dispensations.

²⁹¹ Entry to the stadium is by free tickets.

group.²⁹²

In its quest for internal order using restored traditions the national government may play up to and emphasize the very traditions they are trying to modernise, as well as marginalizing key elements of its future population. This is counter-productive in HIV/AIDS prevention. To contain youth dissent, politicians appeal to the traditional precepts of respect for elders and other values. These constructed socio-economic forces directing the youth into more traditional responses may be countered by the youth preferring sexual and other risk taking to a life of joyless repression, misery and poverty.²⁹³

5.4.2.4 The role of women

These traditionalising imperatives are also seen among women. They derive from a number of perspectives, mostly, as stated, arising from a need to reconcile urbanity and modernity with traditional cultural practices.

A good example I witnessed was the 'shower party', the successor to the kitchen party: in this case my niece, Emma's on 22/7/01.²⁹⁴ Being male, I was not allowed to attend crucial aspects of the party. Yet it was interesting to see highly educated and westernised women effectively recreate a rural ceremony in urban Zomba. Leading advisers and participants in the ceremony included selected leading Zomba matriarchs, effectively acting as *anankungwi*. Rev. Francis Mwawa and his wife (Personal communication, 08/7/01), of Zomba Anglican Church, were extremely critical of this new incarnation from Christian and gender considerations. They felt that the secrecy, involvement of females only and the exclusion of males were counterproductive in instilling equality in the family. From the HIV/AIDS perspective I noted that some

²⁹² For one account of the Malawi Social Action Fund see Phiri, K et al (1998: 83 and 248). The Malawi Social Action Fund (MASAF) was established in July 1995 as a key poverty alleviation instrument. It is community oriented and finances community self help projects (MASAF Factfile, 2000).

²⁹³ In September 2001 one of the Malawi National Economic Council economists stated that the number of Malawians living below the poverty line had increased from 60% before 1997 to 65.3% in 2001 (<http://allafrica.com/stories/200109170424.html>).

²⁹⁴ The Chewa for 'shower' as in 'taking a shower' is *kusamba*. The traditional derivation in dances and ceremonies like *chisamba* (a dance) or *kusamba* (purification ceremony) become clear.

young men I spoke to took it for granted that females were being instructed in fidelity to their husbands, a consideration that did not ('culturally') apply to the men themselves.

These new urban female rites could be viewed as resurgences of localised traditions, traditions that empower leading society females over their peers, reclaiming traditions lost through urbanisation. But the power exercised by these modern *anankungwi*, in an effort to socialise younger females, may, in the HIV/AIDS, and indeed gender battle, be counter-productive, as the male exclusion from kitchen parties shows. Thus, some of these new practices serve to perpetuate traditional stereotypes of different, dependent and *kumpanda* (kitchen compound) based women.

5.4.2.5 Family Planning

My fieldwork did not specifically investigate aspects of family planning knowledge in Malawi. This is a subject that has been recently extensively investigated by the Malawi Demographic and Health Surveys of 1996 and 2000 and, from the perspective of students, in a recent PhD thesis by Chimbwete (2001). Some literature review material has been included in section 5.4.1.5.

5.4.2.6 Non-indigenous religion

The role of non-indigenous religions in influencing and affecting the actions of its adherents can be as ambiguous as that of ATR. One interviewee (Personal communication, Mkandawire, F., 17/7/01) noted that some church going people 'still do all those *ufiti* things'. During my fieldwork, I found that there were, in Zomba, Malindi and Mangochi, many thriving church youth activities, although many of these were related to gospel singing and other 'born again' church activities. I noted that *chokolo* (widow inheritance) practices and related marital behaviour patterns still exist among some Christians. I noted five examples of educated (three graduates) Christian men who had inherited their relatives' widows with tragic results (Personal communication, Mkandawire, A., 17/7/00). There had been clear signs and symptoms suggestive of HIV/AIDS illness in all five cases. Among Muslims polygamy and

multiple marriages continue.

While offering solidarity and an aspirational background most religions fail to protect their adherents from the cultural and economic imperatives of daily living.

5.4.2.7 The value of life

When accompanied by a well-fed and prosperous female companion, male market vendors expressed, in painful detail, their belief that my companion was unlikely to be HIV positive, *muli HIV m'menemu?* (HIV can surely not reside in there?)(Cf. Tavrow, 1994). This discourse clearly suggested that some men still use phenotypic and phenomenological evaluations. Thus, as in pre-colonial times, some men value fatness in women.

Among school dropouts I met in Zomba, Malindi and Lilongwe life-views or outlooks tended to be short term, reflected in proverbs like *mwendo kumangothyoleratu* (make hay while the sun shines). Among the students I noted and recorded *wafa wafa* (you die, you die), *watsala watsala* (the slow coach gets left behind), and other similar expressions, as some commented (during the questionnaire completion session) on the speed of their peers.

Among vendors (the most common urban alternative employment for school-dropouts) these attitudes were more pronounced, and practically applied. These suggest that these youths believe that they have to make the most of it, while they have the chance. Some of the factors which drive these attitudes into fatalistic behaviour include: the poverty, the inferior status and alternatives accorded to peasants in colonial and postcolonial Malawi, the absence of employment and a lack of real alternatives, the limited medical facilities and other factors which make *anthu wamba* (peasants, ordinary people) lives expendable. My respondents saw this as *moyo wakuMalawi ndiwosadula* (life is cheap in Malawi).

Many observers have under-estimated the insights which the youth have in their own miserable lives. From their vantage points many were acutely aware of the gap in

income, nutrition and material well being between them and the Malawian elite. When this gap is extended to the global arena the difference is stark.²⁹⁵

Some of the choices that result from the mentality resulting from these insights may translate into what is often perceived as unexplained high risk taking, in the face of HIV/AIDS. In May 2002, BLM report (Ligomeka, 2002) claimed that 'youthful boredom is keeping Malawi NGO's frantically busy in the battle against the spread of STDs and HIV/AIDS... They indulge in sex because there is a lack of alternative activities'. I would argue that some of these are weighed risks, against the bleak alternatives.

²⁹⁵ The average rural Malawian will be lucky to earn \$2 per day. This (\$2) is what the EEC spends on the subsidy of each cow per day (Marr, A. quoting EEC figures on BBC1 TV News, 7/2/02).

5.4.3 Questionnaire results

5.4.3.1 Vibrant traditional medical practices

Having noted the qualitative findings above, I now set out the quantitative findings in relation to traditional practitioners. When asked ‘Do you believe that the following can be treated by traditional practitioners?’ the responses at different sites was as given in Table 8.

Table 8²⁹⁶

Question: Do you believe that the following can be treated by traditional practitioners?					
Number answering Yes.					
Site	Rheumatism	Malaria	HIV/AIDS	<i>Kukhwima</i>	<i>Ufiti</i>
Primary:					
St. Martin’s n=43	28%	23%	09%	40%	35%
Bwaila n=61	54%	39%	05%	52%	36%
Secondary:					
Mangochi n=15	47%	20%	00%	53%	80%
St. Michael’s n=202	23%	14%	01%	20%	20%
St. Mary’s n=21	38%	24%	00%	43%	48%
Masongola n=18	50%	17%	06%	33%	50%
Zomba Cath. n=16	56%	28%	00%	56%	78%
University:					
1 st Year Phil. n=60	27%	18%	05%	58%	70%
1 st Year Eng. n=98	40%	21%	05%	44%	59%
2 nd Year Biol. n=0					
2 nd Year Th. n=12	42%	08%	08%	67%	75%
3 rd Year Th. n=10	20%	30%	00%	50%	70%

My survey, Table 8, shows that the vast majority of students at all sites did not believe

²⁹⁶ The table only shows the percentage (out of all respondents) that answered ‘yes’.

that traditional practitioners could treat HIV/AIDS. However there was a variable belief in the ability of traditional practitioners to treat rheumatism, *kukhwima* and *ufiti*, varying from a low of 20% (St. Michael's) for *ufiti* to 80% (Mangochi), also for *ufiti*. Overall the responses showed significant levels of confidence in the ability of traditional practitioners to deal with issues of rheumatism, *kukhwima* and *ufiti*.

The perceived ability of traditional practitioners to treat rheumatism varied from 20% (Third Year Theology) to 55% (Zomba Catholic). Surprisingly, the Bwaila figures show that more of these Zomba based children rated traditional medicine more able to treat diseases than the rural St. Martin's. Both Bwaila and St. Martin's are within a mile of hospitals. The reason for the difference is not clear. However, Bwaila Primary caters for many working class families in Zomba.

Traditional medicine was seen as less able to deal with malaria, with from 08% (Second Year Theology) to 39% (Bwaila) stating that it can. Finally traditional medicine was seen as being least able to deal with HIV/AIDS, the responses varied from 00% at Mangochi to only 09% at St. Martin's. Expressed in qualitative terms this translated into comments such as:

Anon, Second year, Theology, Chancellor College (13): 'Some traditional medicine really works beside (sic) western medicine'.

B. Z. age 15, form 2, St Michael's Girls' Secondary school (779): 'Yes traditional practitioners can treat rheumatism, fortification and witchcraft, but not HIV/AIDS'.

T. C. C., age 17, St Mary's Secondary School (45): 'Rheumatism, malaria and HIV can be treated by [*sing'angas*], but HIV cannot be cured'.

Chirwa, F. M., Teacher and Patron of AIDS Club, Bwaila Primary School, (479) '*Sing'angas* can cure malaria and *nyamakazi* (rheumatism)'.

These quantitative and qualitative figures show that while HIV/AIDS is largely seen as the province of hospital medicine, *kukhwima*, *ufiti* and rheumatism are seen as sometimes lying in the province of the traditional practitioners. There was therefore a

significant but qualified role for traditional medicine, as viewed by my respondents. Traditional medicine is not here seen as effective in HIV/AIDS management. I then wanted to find out how many of my students had personal experience of traditional medicine. The question used was: Who first took you to a traditional medical practitioner?

Table 9

Question: Who first took you to a traditional medical practitioner? ²⁹⁷					
Site	Parents	Family/other	Never been	No answer	Total
Primary:					
St. Martin's n=57	44%	10%	14%	32%	100%
Bwaila n=33	55%	09%	21%	15%	100%
Secondary:					
Mangochi n=42	36%	10%	21%	33%	100%
St. Michael's n=59	20%	02%	14%	64%	100%
St. Mary's n=29	07%	10%	52%	31%	100%
Masongola n=32	31%	13%	28%	28%	100%
Zomba Cath. n=39	45%	13%	13%	29%	100%
University:					
1 st Year Phil. n=14	07%	00%	14%	79%	100%
1 st Year Eng. n=33	15%	06%	27%	52%	100%
2 nd Year Biol. n=23	35%	22%	08%	35%	100%
2 nd Year Th. n=21	33%	14%	05%	48%	100%
3 rd Year Th. n=10	20%	30%	20%	30%	100%

At nearly all sites except four (Table 9), three of whose results may have been affected by poor completion rates (St. Michael's, First Year Philosophy, and First Year English), of those who gave an opinion, more students had been to traditional practitioners than had not been.²⁹⁸ These affirmative responses varied from a low of

²⁹⁷ Figures have been rounded to the nearest whole number. All horizontal columns total 100%.
²⁹⁸ The high numbers of those not responding at some sites represent incomplete questionnaires, those who did not want to reveal whether they had been to traditional practitioners and those who simply skipped the question.

07% (First Year Philosophy) to 64% at Bwaila, which may give a clue to why students at Bwaila had more confidence in traditional medicine than their St. Martin's counterparts. Interestingly, primary school students were more likely to remember having been to a traditional practitioner than those in secondary and tertiary education. Primary students appear to use traditional practitioners more at Malindi and Zomba, despite their ability to access western medicine at these sites. No comment can be made for the secondary and tertiary students previous access to western medicine as their previous schools may have been situated far from western medical facilities. Next, I wanted to see if my students were aware of any shortcomings in traditional medicine. I was attempting to establish their views on the validity of traditional medicine. The implied question was: Can traditional medicine harm people?

Table 10: Respondents answering as indicated. Horizontal columns total 100%.

Traditional medicine can harm people.						
Site	Always Frequently		Sometimes	Rarely	Never	No answer
Primary:						
St. Martin's n=57	11%	05%	33%	04%	14%	33%
Bwaila n=33	15%	12%	37%	09%	06%	21%
Secondary:						
Mangochi n=42	12%	14%	48%	00%	09%	17%
St. Michael's n=59	10%	15%	17%	03%	02%	53%
St. Mary's n=29	14%	38%	35%	10%	00%	03%
Masongola n=32	22%	31%	41%	03%	00%	03%
Zomba Ca. n=39	13%	08%	40%	08%	05%	26%
University:						
1 st Year Ph. n=14	00%	14%	07%	00%	00%	79%
1 st Year Eng. n=33	06%	24%	24%	00%	0%	46%
2 nd Year Biol. n=23	09%	04%	22%	22%	04%	39%
2 nd Year Th. n=21	09%	05%	48%	05%	05%	28%
3 rd Year Th. n10	10%	20%	40%	10%	00%	20%

Table 10 shows that, at all sites, my respondents were aware of the fact that traditional medicine can cause harm. At most sites, except First Year Philosophy (00%), from 06% (First Year English) to 22% (Masongola) of the respondents saw traditional medicine as

always causing harm. The rural St. Martin's (14%) and Mangochi (09%) excepted, no other sites had a corresponding response, at the other extreme: that it never caused harm. In between there was a spread of opinion between those who thought that the harm occurs frequently, sometimes or rarely, most responses here stated frequently or sometimes.

The students were generally more of the opinion that it can always or frequently cause harm, than that it rarely or never caused any harm. This was the opposite of the findings with the Statement: 'Western medicine can harm people' dealt with below (Table 11). Some of the reasons for the replies are explained by some of the qualitative replies:

Anon, Year I, Humanities (English), Chancellor College, (598):
'Traditional medicine has no dosage as compared to hospital medicine.
Usually this is the reason why traditional "meds" are hazardous'

Here traditional medicine was clearly seen as less scientific or rigorous than its western counterpart (Cf. Table 10 and 11).

The Table 11, as stated above, contrasts with that for traditional medicine in being more weighted towards the 'Rarely' and 'No never' end. However, the students, as shown by the 'Sometimes' and 'Rarely' responses, are not idealistic about western medicine. Interestingly, the most significant 'No never' responses were seen at the Primary schools, both urban and rural, and at the Mangochi and Zomba secondary schools. It is speculative whether the proximity of hospitals near these schools, hospitals to which healthy school students are rarely exposed, is responsible. The university students, selected from across all the districts, perhaps from experience, did not have such an unqualified view of western medicine. In qualitative terms, the views of the students were:

W.L., age 18, St Mary's Girls Secondary School (82): 'Western medicine can be harmful to a person who is careless'.

Saima, S. age 16, form 1, Zomba Secondary School (388): Western medicine can harm when taken in overdose

The students saw harm in western medicine as arising from misuse or overdose, rather

than the inherent nature of western medicine itself. This contrasts with traditional medicine where the fault lay in its less scientific nature.

Table 11

Respondents' answers to the statement (all horizontal columns total 100%):						
Western medicine can harm people.						
Site	Always	Frequently	Sometimes	Rarely	Never	No answer
Primary:						
St. Martin's n=57	05%	04%	26%	09%	26%	30%
Bwaila n=33	03%	06%	36%	9%	40%	06%
Secondary:						
Mangochi n=42	00%	02%	55%	12%	21%	10%
St. Michael's n=59	05%	00%	39%	07%	19%	30%
St. Mary's n=29	00%	00%	45%	35%	17%	03%
Masongola n=32	06%	00%	66%	03%	22%	03%
Zomba Ca. n=39	00%	00%	45%	18%	26%	11%
University:						
1 st Year Ph. n=14	00%	00%	07%	21%	07%	64%
1 st Year Eng. n=33	00%	06%	39%	12%	03%	39%
2 nd Year Biol. n=23	04%	00%	61%	18%	04%	13%
2 nd Year Th. n=21	00%	05%	57%	24%	05%	09%
3 rd Year Th. n10	00%	10%	80%	00%	10%	00%

Having obtained some idea of their opinion of traditional medicine, I next sought to assess their future intention to use traditional medicine themselves (Table 12).

Table 12 shows that between 49% (Bwaila) and 58% (St. Martin's) primary school students who answered the questionnaire are open to the possibility of future use of traditional medicine. This intention falls to between 32% (St. Michael's) and 52% (Mangochi) in secondary school. Among those in junior university it varies between 14% (First Year Philosophy) and 67% (Second Year Theology), before peaking at 70% among the Senior Theology class. It will also be noted that at all sites except St. Michael's, Masongola and Zomba Catholic, of those who filled this part of the

questionnaire, more expressed a positive intention to use than those who did not. Over 45% of primary students intended to use traditional practitioners in future.

Table 12

Question: Do you intend to use traditional medicine in future?					
	Yes (Definitely)	Yes (Maybe Probably)	Yes (Total)	No (Unlikely Never)	No answer
Site:					
Primary:					
St. Martin's n=57	21%	37%	58%	16%	26%
Bwaila n=33	18%	30%	49%	45%	06%
Secondary:					
Mangochi n=42	14%	38%	52%	33%	14%
St. Michael's n=59	02%	30%	32%	34%	34%
St. Mary's n=29	03%	45%	48%	48%	04%
Masongola n=32	13%	31%	44%	56%	00%
Zomba Cath. n=39	08%	26%	34%	55%	11%
University:					
1 st Year Ph. n=14	07%	07%	14%	14%	72%
1 st Year Eng. n=33	12%	30%	42%	18%	40%
2 nd Year Biol. n=23	22%	22%	44%	39%	17%
2 nd Year Th. n=21	05%	62%	67%	24%	09%
3 rd Year Th. n=10	40%	30%	70%	20%	10%

Over 30% of secondary school students intended to use traditional medicine and (excepting the First Year English) over 40% of tertiary students intended to use traditional medicine.²⁹⁹ In the case of Zomba Secondary, a Catholic run secondary school on which the Catholic Marist Brothers still have a considerable degree of control, and Masongola both of which had a good response rates, the majority (55%, and 56% respectively) did not intend to visit traditional practitioners in future.³⁰⁰ The

²⁹⁹ St Michael's and First Year Philosophy questionnaires were affected by item non-response.

³⁰⁰ Although the central government assumed control of selection to secondary schools in 1964, the economic factors have led to Christian schools regaining some of the autonomy – and control of the religious curriculum - they had lost in the seventies and eighties.

difference between the rural St. Martin's where only 16% did not intend to use traditional medicine and Bwaila, an urban primary school, where as many as 45% did not intend to use traditional medicine, reminds us that the Bwaila students appear more exposed to traditional medicine than St. Martin's students. Interestingly the highest affirmative rates, for future use of traditional medicine, were among Theology students and the two rural schools where there were good questionnaire completion, St Martin's and Mangochi Secondary School. At the extremes the students appear more willing to use traditional medicine, in the primary case perhaps due to family influence, and among the seniors perhaps some disillusionment with western medicine. I will now contrast this with a similar exercise involving western medicine.

Table 13

Question: Do you intend to use western medicine in future?					
	Yes definite	Yes maybe	Total Yes	No/ never	No answer
Primary:					
St. Martin's n=57	52%	15%	68%	09%	23%
Bwaila n=33	67%	21%	88%	06%	06%
Secondary:					
Mangochi n=42	60%	24%	83%	05%	12%
St. Michael's n=59	47%	15%	63%	02%	35%
St. Mary's n=29	65%	27%	93%	03%	04%
Masongola n=32	66%	28%	94%	06%	00%
Zomba Cath. n=39	61%	26%	87%	05%	08%
University:					
1 st Year Ph. n=14	28%	00%	29%	00%	71%
1 st Year Eng. n=33	46%	18%	64%	03%	33%
2 nd Year Biol. n=23	74%	09%	83%	04%	13%
2 nd Year Th. n=21	62%	24%	86%	09%	05%
3 rd Year Th. n=10	80%	20%	100%	00%	00%

Of those who answered this section of there was an overwhelming majority of those who intended to use western medicine, with a clear preponderance of those answering 'yes definitely'.

It would be illuminating to revisit the causality debate at this point to see if the decisions are influenced by the beliefs in causality of the students, see Table 14.

When asked, 'What, in your opinion, causes disease?' most of my respondents accepted the germ theory of disease:

Banda, age 19, form 4, Zomba Catholic Secondary School (400) 'Germs'.

But there were some who considered that other possibilities existed:

Simbota, I, age 17, Zomba Secondary School (35:9) 'All diseases mentioned [here] are [not a problem] if one believes in God'.

Yet some of my respondents who held to the western causation theories went further and completely discounted *ufiti*:

:

F. M. N., age 17, form 3, Mangochi secondary School (303): the HIV virus causes AIDS. The diseases like AIDS, malaria, rheumatism are not caused by witchcraft but there are certain harmful micro-organisms that cause [them].

Although the conclusion could be that some students merely gave the expected scientific answers, from one perspective it shows that their education had, in this specific area at least, indeed transferred this scientific knowledge of HIV/AIDS.

In quantitative terms the replies were as shown in Table 14.

The urban Bwaila primary school overwhelmingly endorsed the germ theory, although 06% gave *ufiti* as the cause. At St. Martin's there was a 11% group who believed in God as the cause of illness. Those who saw *ufiti* as the cause of illness at all sites ranged from 00% (at four sites) to 08% (Zomba Catholic). At St. Mary's, the combination of *ufiti* and germs was mentioned by 10% of respondents. Interestingly, the highest percentage of those who saw *ufiti* as a cause of illness was seen among the Second Year Theologians; but this again fell far short of Hopkins' (1980: 56) figures.

At Masongola, Mangochi, St. Martin’s, St. Mary’s, Third Year Theologians, First Year English, St. Michael’s and among the First Year Philosophy students, there were small percentages ascribing illness to, among other things, Satan, Germs, God, hunger and anxiety; these varied from 03% (First Year English) to 20% (Third Year Philosophy).

Table 14

Question: What in your opinion causes illness? (All figures are percentages)									
Site	Germs	Ufiti	Ufiti and germs	Satan	Germs other hunger anxiety	God	Don't know	No answer	Total
Primary:									
St. Mart. n=57	47	04	02	00	00	11	08	28	100
Bwaila n=33	82	06	00	00	00	00	03	09	100
Secondary:									
Mangochi n=42	67	02	00	00	07	02	22	00	100
St. Mich. n=59	53	00	00	02	00	05	08	32	100
St. Mary n=29	66	00	10	04	07	00	03	10	100
Mas/ola n=32	69	06	00	03	06	10	03	03	100
Zomba n=39	71	08	00	00	00	00	08	13	100
University:									
1 st Y/Ph. n=14	36	00	00	00	07	00	00	57	100
1 st Y/Eng. n=33	58	03	03	00	03	00	00	33	100
2 nd Y/Bio. n=23	74	04	04	00	00	00	09	09	100
2 nd Y/Th. n=21	72	00	14	00	00	00	04	10	100
3 rd Y/Th. n=10	70	00	00	00	20	00	00	10	100

It is interesting, given the emphasis of this study on the role of poverty, that some respondents saw hunger and anxiety as causes of disease.

This section confirms that most of my student respondents were aware of causality in

western terms. There were small pockets of those who ascribed illness to *ufiti*, Satan, God, anxiety and hunger.

5.4.3.2 Family Planning and sexual health

My survey was not specifically about family planning. However one aspect I was interested in is the knowledge among female secondary school students of how to specifically prevent STDs, including HIV/AIDS.³⁰¹

Education is meant to empower female students. In the HIV/AIDS arena this empowerment can only be said to be present if female students are aware of the practical strategies for self-protection. This is the aspect I wanted to explore. Table 5.4.3.2 (i) shows how the female students view HIV/AIDS prevention, and indirectly sexual health.

The table shows that there is a good level of awareness of ways of avoiding sexually transmitted diseases. However, this awareness is largely built on the concept of abstention and ‘avoidance of casual sex’. This awareness is, from a medical point of view, largely aspirational and, arguably, not pragmatic, given that the majority of students progress to sexual activity by age 18 (Chimbwete, 2001: i).

These girls’ schools are therefore not imparting the practical advice, which would be given to girls of similar age in the UK for instance, which emphasise safe sex (UK HIV/Sexual Health Strategy, 2001).³⁰²

From a practical point of view, the secondary schools are not ‘empowering’ girls in their future sexual lives. An aspirational empowerment, as is shown here, in the age of HIV/AIDS has the same potency as religious or cultural strictures to abstain. As seen by the figures in Table 15, the numbers of girls who are aware of, or articulated, safe

³⁰¹ For this reason at Masongola, only the female students were recruited. This was to ensure a better rural/urban balance as I had been promised 200 students at St. Michael’s Secondary School.

³⁰² The UK national HIV/Sexual health strategy (2001) includes elements of funded prevention, service provision and evaluative components. It recognises (page 5) that there is a relationship between ‘sexual ill health, poverty and social exclusion’.

sex are woefully tiny.

Table 15

Question: How do you prevent HIV/AIDS? ³⁰³ (All horizontal columns total 100.00%)							
	Abstain	Avoid	Condom	Premarital	Adopting	Avoiding	No
		casual	use	check-ups	safe sex	body fluid	ans.
	Sex			condoms	practice	blood,	
				abstain		tooth	
						brushes	
						razors	
Site:							
S/Michael's							
(n=59)	37	25	14	03	03	00	18
S/Mary's							
(n=29)	45	28	07	00	00	13	07
Masongola							
(n=32)	28	57	00	03	03	03	06

A related aspect of importance here is the premarital check-up. A girl or boy who has abstained must clearly be accorded a pre-marital check-up by their partner to ensure that she is not infected by a future spouse, or if the spouse is HIV positive has the option to protect her or himself. Again this knowledge does not appear to be imparted.

5.4.3.3 Non-indigenous religions

Some examples of extreme Christian and syncretic beliefs were noted in some of my student responses:

Chindola, L age 16, Bwaila Primary School (482): *'ndili mu mpingo wosadya mankhwala. Panopa ndikadwala ndimangopemphera'* (I belong to a church that does not use medicines. At present, if I fall ill I depend on prayer).

³⁰³ 'How do *you* prevent HIV/AIDS?' was preferred to 'How does *one* prevent HIV/AIDS?' as this is the usage understandable to most Malawian primary and secondary students.

Anon Biology, Chancellor College (287): avoid *ufiti* by believing in God [but] '*ufiti* works'.

Similarly some churches, as noted in Chapter Four, do not permit the use of condoms. The religious strictures, according to this survey, do offer a crucial period of, if only aspirational, protection for some secondary school students. Views like:

J. M. age 12, form 7, Bwaila Primary School (413): 'stop (sic) yourself from bad desires' [is the only way to prevent AIDS].

do have an impact, which may, for some, last while they are in the early years of secondary school. But given the poverty and temptations of peers and sugar daddies, they probably require other fallback strategies.

5.5 Oral Discourse, music and language

From an examination of the value of life in 5.4.2.7 it appears that the role of oral discourse in Malawi is helpful in illuminating both attitude and behaviour. Before proceeding further it would, as the discourse of *ufiti* and *kukhwima* is largely in the vernacular, be useful to look at oral and musical discourse.

5.5.1 Oral Discourse and language

During my fieldwork I observed the frequent use of cultural signifiers in ordinary oral discourse; these were often stated in normative terms, and could be held to have normative functions. For example, there were frequent references to *zaufititu izi* (this is witchcraft) to signify abnormal or aberrant behaviour. Such stances or descriptions were meant to give a critique of, or designed to redirect behaviour or conversation thought to aberrant. Other common examples, in both 2000 and 2001, involved the use of the terms: *wopita kumaliro* (one who attends funerals) and *wopanda khanza* (one without cruelty). People with these attributes were held to be normal caring social beings³⁰⁴. The negative side of the attributes were always included, or implied, in the

³⁰⁴ Following this behaviour by the State President Bakili Muluzi, and the use of these terms by the

epithets. The normative power of these epithets is shown by the fact that the new President had appropriated some benign normative epithets for himself. As a disposer of power and maintainer of order, it was necessary to show that he was still as powerful as Dr Banda but used his benignly. This similarity in the magnitude of his power and difference from the cruelty of Dr Banda led to the coining of the slogan: *kumtunda wopanda nkhanza, ndinso wopita kumaliro* (the powerful benign president who attends funerals). The implication being that, like Banda before him he had the social [and as noted earlier] medical interests of his people at heart, but unlike Banda, he is a caring social being, a true follower of Malawian traditions. Thus even if his government has some failings in the economic arena, these are not for want of caring. Cultural signifiers are thus, post-Banda, still used to construct new socio-political cultural norms based on appropriated rural traditions. In the context of the HIV/AIDS discourse they afford governance a ‘cultural alibi’ for deficiencies in medical services.

5.5.2 Language

The same considerations also necessitate the examination of the medium for transmission of health promotion messages. Most health promotion workers use English. The power of the vernacular languages to transmit traditional cultural values from home to village schools has been alluded to in Chapter Three.

With reference to our primary school students, in 1997, a consultative symposium recommended to the Ministry of Education that the preferred languages of instruction in primary schools should be vernacular for the first four years. It suggested that school children ‘are better able to grasp the concepts of learning in their own languages’ (Kamwendo, et al, 1999; Mtenje, n.d.: 3). Despite the debates and suggestions, among elites, that tend to hold that local languages are not capable of accommodating new technological advances, participant observation in markets and urban areas do not support this argument.³⁰⁵ I found that *anthu wamba* vendors deal with concepts of

UDF in praising him.

³⁰⁵ For these elite debates, see for example the *Nyasanet* (nyasanet@maelstrom.stjohns.edu) and *Malawitalk* internet (malawitalk@mailtalk.ac.uk) archives. On the Nyasanet discussion forum (1997 – 2001) some elites argued that rural people could not grasp the concepts of [modernity] due to limited or

‘digital’, ‘video’, ‘investment’, ‘computer’, and all the other goods they sell, without apparent confusion, limitation or difficulty.³⁰⁶ The difference is perhaps that they are dealing with the foreign concepts on their own utilitarian terms, and utilising their utility within the contexts of their real lives. Elites, on the other hand, whose possession of English is a key to economic power, promise the *anthu wamba* a better life for those without English as soon as they master it.

This class and rural urban dichotomy also affects the health promotion industry which, in Malawi is largely donor funded, and thus issues of access to its economic advantages pertain. Health promotion messages are, as noted for HIV/AIDS, thus originated in the language of power, English, and translated into the vernacular. These translations usually dilute the power of the health promotion messages. There is a case for drafting health promotion messages in the indigenous languages, an undertaking of which most Malawian health workers are capable. Yet, even in 2002, health promotion posters targeted at rural areas still prefer English, for example, the potentially very useful: ‘AIDS IS NOT WITCHCRAFT’ is not always translated (to ‘*EDZI SI UFITI*’).

Vernacular languages possess more power, meaning and flexibility, outside the minority formal sector, than is usually conceded by the educated elite. They after all control the process of information transfer. Indeed, in political power discourse, and in theology, Malawian politicians and religious preachers respectively - now that it is acceptable to use vernacular languages in national fora - increasingly resort to vernacular proverbs to deliver ‘killer’ points of argument.³⁰⁷ The Malawi Catholic Bishops for instance (Lwanda, 1993: appendix) quoted *mutu umodzi susenza denga* (one head does not possess all knowledge) to undermine the concept of Banda’s omnipotence. Rural musician Alan Namoko had, in his popular hit *Mutu umodzi susenza denga*, already used this proverb a few years before the Bishops. In his song criticising corruption, Matafale (2000) chose the expression *watsetsereka* (you have slipped) to demonstrate the slippery nature of associating with corrupt people; sooner or

absent English. In their song *Ndachita manyazi*, the Police Orchestra critique the mores of the young using the very language the *anthu wamba* are not supposed to understand. In the song designer clothes with deliberately sewn on patches are called *zobvala za zigamba za original* (clothes with original rags)

³⁰⁶ See Kasambwe Brothers Band *Nambewe* (1994) and Cf. the Nyasanet Discussion forum referred to above (Nyasanet@maelstrom.stjohns.edu, 1997 – 2001).

³⁰⁷ See, for example, Chakanza (2000: 9 - 12).

later you slide (*kutsetsereka*) into the corruption. The impact of this vernacular expression was such that *kutsetsereka* (to be on the slippery road to corruption) is currently a common expression. In similar vein, Billy Kaunda (1999) used the expression *kale likati lidzibwerela* (the past threatens to return), even before the journalists and political commentators picked on it, to point out the 're-autocratisation' tendencies in some UDF elements. The inevitable presidentialism, with its ability to appropriate vast resources for administrative rather than service provision, is clearly alluded to in the song, as is the fluidity of political party personnel for personal gain.

The popularity of the vernacular may be explained by the type of proficiency achieved by most school leavers in English. For many of these their English is functional rather than adequate to discourse on profound issues. Therefore speaking in the vernacular affords them more depth and power. It is noticeable that in the reggae format popular with senior primary and secondary school leavers, the English used tends to be polemical. When the musicians want to express profound ideas, these are given in the form of vernacular proverbs or discourse. As seen below code switching and code mixing are utilised.

Proverbs, whether in song or oral discourse, are thus powerful formative tools whose advice is reinforced by daily discourse: *mako ndi mako usamuone kuchepa mwendo* (even with a short/deformed leg, she is still your mother), *waziputa limba* (do not start anything you cannot finish) and so on. It has previously been noted that musical and oral discourse contains significant traditional themes. If a meaningful dialogue between traditional and western medicine is to thrive, such themes need to be exploited, and similar discourse utilised. As shall be noted in the next section, this discourse is often utilised to express beliefs and attitudes.

Crucially, language also functions as a tool of, and reflector of, the multiple identities, which school youths adopt in daily life. In exploring code switching and code mixing among bilingual Malawians, Kayambazinthu (1998: 19 – 43) seeks to understand the relationship 'between linguistic forms and social processes in the interpretation of experience and the construction of social reality'. Kayambazinthu (1998: 23) asserts (after Heine, 1990: 177) that

the 'horizontal media (indigenous languages) are associated with solidarity and social equality, while the vertical media (colonial languages) imply distinctions in role expectations, status, prestige and socio-economic stereotypes. Consequently, colonial languages may signal authority or even superiority, while the indigenous ones may be employed to play down personal aspirations and to emphasise egalitarian attitudes. In the African context, languages such as English, French and Portuguese came with political power and western institutions, the possession of which gave one prestige and high social status. The indigenous ones, on the other hand, expressed the African way of life, one's relationship with members of one's family and members of the ethnic group

Thus, Kayambazinthu identifies a number of reasons for code switching among Malawians: economy or precision of language, exclusion, secrecy, abuse or façade, and, of relevance to our discourse, multiple identities. In her terms these multiple identities encompassed national, ethnic and socio-economic status. The use of code switching was found to be conscious and unconscious, often for pragmatic reasons. For our subject the relevance of code switching is in its function as a tool of multiple identity construction. One of Kayambazinthu's fieldwork examples concerns a western educated man living with a foreign woman. As the relationship sours, he tells his friends within her earshot, in Chichewa, a language the lady does not understand, that she is only there 'to clean up the place'. The man brags about his infidelity using a Chewa proverb that invokes the 'traditional tolerance' to infidelity

Tonde azinunkha (A male goat should prove itself). (Kayambazinthu, 1998: 31).

The insights from a study of language and daily oral discourse in the HIV/AIDS debate thus become clear. The man is living in a duality, a duality that excludes the potential wife from some aspects of his behaviour. His behaviour, as an educated man with means, is facilitated by the use of language to negotiate what would otherwise be a problematic duality. Bilingual Malawians use language to move in and out of culturally determined situations. This fluidity is reflected and part of the same approach used in dealing with reactions to sexual behaviour patterns. The more educated and affluent the Malawians are, the more opportunities for this duality.

It is this ability to appropriate and corrupt cultural norms that is relevant to our HIV/AIDS study. Within the indigenous cultural traditions, some of which are promotive of HIV/AIDS, we note that further corruption by powerful players may be possible, stretching even the liberal heterosexual norms even further.

A related feature of this ability to use language to switch between cultural spaces in Malawian public culture is the tendency to avoid some subjects by resorting to what has, in this work, been termed *ufiti* discourse. I found that this is done for a number of reasons: to maintain or preserve a mystical construct, to stop a certain direction of discourse, and as an ultimate explanation that does not cause communal or societal distress or disorder. *Ufiti* discourse is also used in light-hearted banter as a joke or in ironic vein by westernised Malawians who understand that the explanation of *ufiti* in that particular situation is inadequate. However, of relevance to our study, is the use of *ufiti* discourse by elite Malawians to engage with rural Malawians in ways that explain things of disadvantage to the rural dwellers while preserving elite advantages. We shall examine this use of *ufiti* discourse in my study of the use by the Malawi Broadcasting Corporation of programmes like *Za m'maboma* (district news) and *Mauthenga achisoni* (messages of condolences). For example, by labelling something *zosachulidwa* (things you do not talk about) or by signifying to the speaker *mutilaulira* (you will provoke the wrath of the Gods) *ufiti* discourse can be used to stop conversation that seeks to explore beyond what the person invoking *ufiti* wants. Even in elite circles discussion of *ufiti*, at all levels of the discourse (light-hearted, agnostic and serious) is common. Examples of *Ufiti* discourses may be found among Christian and Muslim groups in Malawi.

We will explore more of *ufiti* discourse in 5.6.2, where it will be demonstrated that, although the direct school responses indicate small belief in *ufiti* causing illness, in the context of HIV/AIDS *ufiti* constructions may be powerful in other indirect ways. From the HIV/AIDS perspective, *ufiti* discourse may undermine conventional health promotion messages by sowing the seeds of causality doubt, for example ascribing illnesses, particularly sudden HIV related illnesses to witchcraft.³⁰⁸

³⁰⁸ For example cases of tuberculous or cryptococcal meningitis, sudden difficulty with swallowing or other acute presentations of HIV/AIDS.

Significantly, HIV/AIDS awareness texts in Malawi tend to be in English, whose use may recruit western values, inherent in the original British or American English texts, into play.³⁰⁹ These English texts may also fail to neutralise the subtle nuances of *ufiti* discourse.

5.5.3 Musical Discourse

Music is extremely important in disseminating messages in Malawi (Chilibvumbo, 1972; Phiri, K., 1972; Chimombo & Chimombo, 1996). Because of potential conflict with governance, in colonial times, as at the 2000 Independence celebrations, musicians often dressed their strong traditional lyrics in genteel presentations. Popular music in rural and urban areas contains, as we will show, a significant element of traditional content. Music lyrics are likely to contain as many references to ancestral worship, sorcery, medicine, healing, poverty and other normative and formative cultural idioms as to love and politics.

With reference to politics, the youths - who pioneered the *jazz band* genre between 1964 and 1974 - used the concept of *nzeru zatha* (brain death or lack of further ideas) to critique political leadership.³¹⁰ Musical lyrics also reflect the certainties and uncertainties of Malawi's multiple cultures. It is, after oral discourse, the most effective and far-reaching medium in Malawi for disseminating health promotion messages among the general and student populations.

Having noted the cultural and HIV/AIDS messages in many of the songs I was hearing, and having noted the importance of music as a medium in Malawi, I set out to investigate the themes, relevant to my study, that were present in Malawian musical discourse.

³⁰⁹ Because texts are in English, it is assumed that Malawian school children who understand English will also understand the messages, cultural factors are ignored.

³¹⁰ Jazz bands were rural and peri-urban musical groups comprising, mostly, unemployed school leavers who used homemade acoustic musical instruments (See Kubik, 1987, Lwanda, 1994 and 2001). A jazz band called *Nzeru Zatha Jazz Band* existed in the 1970s (Kubik, 1987: 29).

5.5.3.1 Themes relevant to HIV/AIDS discourse in broadcast and recorded music

To demonstrate the significance of social, religious, political and other themes, relevant to HIV/AIDS in Malawian popular music I analysed the contents of contemporary cassettes, radio programmes and colonial recordings. I was looking for social-cultural, socio-economic, political and medical contents of the recordings and programmes. My aim was to demonstrate the validity of the musical and oral public sphere relevant to HIV/AIDS, I was proposing.

Section Methodology

I undertook:

- An analysis of the Malawi section of Hugh Tracey's (1973) *International Library of African Music* field Long Play recordings (n=24) from 1949 - 58 records in my archives. These recordings, with 371 tracks in total, give a flavour of the rural public sphere before this was extensively invaded and partially appropriated by modern mass media.³¹¹
- An analysis of the contents of a batch of commercial popular music cassettes released in Malawi between 1998 and 1999. These were randomly acquired in the following manner: I bought an entire batch of all available new release 1998-1999 cassettes (53 in number), stocked since my previous visit, from the *Portuguese Centre* in Blantyre, one of the major cassette dealers, during a field trip in July 1999 (Cf. Lwanda, 1999: 533 – 538). From these 41 were randomly picked and analysed. This analysis involved listening to 425 tracks.³¹²
- I also analysed the musical content of some randomly taped MBC programmes broadcast between 1975 and 1999.³¹³ For this study the *mbumba*³¹⁴ and *Nyimbo*

³¹¹ The International Library of African Music, Rhodes University, Grahamstown, was compiled between 1949 and 1958, a time when radio had not achieved the extensive penetration of the rural areas which occurred soon after independence.

³¹² The limiting factor was time: it took, on average, two days to analyse each cassette.

³¹³ Tapes in my personal archives.

³¹⁴ Political songs by MCP party women. See, for example, Lwanda (1993) and Chirwa (2001).

*za m'maboma*³¹⁵ musical tapes in this group were excluded, these were not randomly recorded. Here there were 241 pieces of music to be examined.³¹⁶

I divided the music into seven categories. The categories were partly influenced by MBC programmes, the requirements of this thesis and subjective categorization. They are:

- Pop. This was defined as music concerned with self-delectation, love, pure dance and pleasure.
- Sociological. This was music involving social themes, culturally formative, normative or directive, and also music involving communal affairs.
- Gospel. This was religious music both Muslim and Christian of religious praise.
- Political songs were those that dealt with issues of governance, both national and local, colonialism and nationalism.
- Economic music dealt with employment, poverty and financial issues.
- Medical songs were those that dealt with specific references to illness without causality issues.
- Traditional music was defined a traditional music, popular music with indigenous proverbs, traditional music with religious and philosophical themes, music derived from or of rituals, and songs dealing with causality issues, for example witchcraft and *kukhwima*.

Data Results and analysis

The results are shown graphically in Table 16.

The International Library of African Music (ILAM) data representing the colonial situation, and the closest to *mphonje* (the pre-colonial era) I could get, shows that, of all tracks: 46% were categorised as sociological, 27% traditional, 15% pop, 04% political,

³¹⁵ Songs from the districts. Although these were originally traditional songs, after the late 1970s many of these songs carried lyrics praising Dr Banda. The other reason for excluding *nyimbo za maboma* and *mbumba* music was the fact that I had specifically asked for these to be taped for me over the years in my pursuit of inside knowledge of Malawi politics, whereas the other MBC tapes were randomly taped.

³¹⁶ Mkamanga (1998) and Muyebe & Muyebe (1999) discuss *mbumba* music from gender and religious perspectives, respectively.

04% economic and 03% religious.

Table 16

<u>An analysis of the lyrical content of broadcast, archive and cassette music in Malawi.</u>							
(All figures are percentages and horizontal columns total 100%)							
Type	Social	Tradition	Popular	Religion	Politics	Medical	Economic
ILAM (n=371)	46	27	15	03	04	01	04
Cass. (n=425)	41	11	05	32	06	02	03
MBC (n=241)	43	14	23	16	03	01	00

Of the randomly selected commercial cassette tracks: 41% were classed as sociological; 32% were religious, 11% had clearly identifiable traditional themes; 06% were political and 05% popular.

Of the MBC musical sampling: 43% of tracks were sociological, 23% were classified as popular, and 16% were classified religious and 14% traditional. There were no identifiably economic songs but 03% were classified as political.

There are noticeable trends here:

- This is largely a social public sphere.
- The constancy of the social component perhaps underpinning the social - as opposed to economic or political - nature of this public sphere is demonstrated by the remarkably similar figures: 41% (cassettes); 46% (ILAM) and 43% (MBC).
- Contrary to the perceived view, politics accounts for relatively little input of music composed voluntarily by musicians, whether professional or amateur. Shorn of the *mbumba* component the political content of the samples are 04%

(ILAM), 06% (cassettes) and 03% (MBC).

- Economic matters are also expressed within a social context. Despite the freedom to express economic dissatisfaction, at 03% the economic component of the cassettes is less than the 04% (ILAM) of the colonial era. The MBC's zero (00%) economic quotient is a factor of the censorship of the MBC by both Banda and Muluzi era MBC administrators. While some would view the low 04% economic quotient of the colonial era as a function of censorship, this has to be balanced by the fact that these were field recordings by Tracey whose knowledge of Chewa was minimal. As such he would, despite his translators, be less likely to censor field recordings. The contents of the recordings suggest a considerable degree of freedom of lyrical expression here. This suggestion of a reduction in the ability to express economic dissent must be viewed against the ability of the postcolonial governments to enter localized public sphere spaces due to the governing elites, and their agents, understanding of local languages.
- The relative paucity, despite the pervasive presence of illness and disease in Malawi, of medical discourses, whether referring to specific illness or personal stories, as opposed to the social approach; disease is seen very much in social terms. Songs dealing with HIV, such as *Tikutha* (we perish), *Ndichiritseni* ([God] heal me) and the Police Orchestra's *Kunja kwaopsya* (There is danger out there) are usually composed in a social vein.³¹⁷
- The fact that 11% of tracks in pop music cassettes had traditional themes, 14% in the MBC samples and 27% in the ILAM samples. Allowing for the skewing due to *mbumba* and *nyimbo za maboma* tapes, which were excluded, (and the 'sponsoring' gospel in the cassette music tapes) the traditional component of this public sphere is probably around 25%.
- The constancy of the combined traditional/religious component: 30% in both the MBC and ILAM figures. The cassettes figures may be skewed by the gospel (Christians) subsidising the cassettes.³¹⁸
- It is noted that the combined religious and traditional components in the cassettes and MBC (excluding *mbumba*) samples give figures of 30% and 43%

³¹⁷ In *Kwaopsya* the Police Orchestra liken the battle against HIV/AIDS to war, the bullets of HIV are its *tizirombo* (viruses) and the people's shields are condoms and communal action.

³¹⁸ Gospel cassettes may have some secular and traditional music.

respectively. This tends to indicate a highly moralistic, normative and formative, as well as still traditional public sphere.

This provisional assessment supports the historically derived concept of a public music sphere. This is based on the constancy of the traditional and social components observed in the colonial, commercial and broadcast samples. The suggestion is of a musical public sphere in Malawi, which shows specific components. By examining these components we conclude that medical messages are passed via social rather than specifically medical discourses. The best way of dealing with HIV/AIDS awareness messages, in such an oral culture, it is suggested, may be to target them via social rather than medical songs. The Health Promotion Unit band of the Ministry of Health, while using conventional medical discourse, attempted this on a small scale in the 1990s.

In primary schools where music is often used this music is usually that derived from colonial era songs. Most of these are nursery rhymes converted into Malawian songs by changing the lyrics and adapting some of the melodies. Some, like, *Kodi inu mwapesa?* (Have you combed your hair?) emphasized cleanliness. Because of the prevailing political climate in the Banda era few teachers were brave enough to adapt traditional songs for developmental purposes. While popular music is much more potent than the music currently used in schools, there are some anti-developmental messages within popular music, particularly in relation to gender (Lwanda, 2001). An analysis of the lyrics of popular music showed anti-gender equality lyrics. The planned use of some modified and evaluated popular messages in HIV/AIDS prevention may improve the delivery of these messages.

5.5.4 Conclusions

The various beliefs, which impact on HIV/AIDS, are manifested in many features, practices and discourse of daily life. This section shows that daily discourse reflects daily socio-economic realities as well as moral and higher concerns. This discourse is mainly social and has the added burden of orality, ambiguity. This ambiguity and orality lends itself to adaptability, subversion, dilution (for example with *ufiti*

discourse) and obfuscation; all factors crucial in HIV/AIDS debates.

The situation of medical issues in the social public sphere begs a revision of how health promotion issues are formulated and disseminated.

One of the markers in my study was *ufiti* (witchcraft) and it is to this that we now turn.

5.6 *Ufiti*.

5.6.1 Literature review

Literature reviews, as already stated in Chapter Four, showed that awareness levels for HIV/AIDS are very high in the general population. Awareness of malaria among the general population was similarly high. I was not able to find any recent work referring to *kukhwima* (fortification).³¹⁹ And references to *nyamakazi* (rheumatism) were limited to clinical texts. Even though *ufiti* discourse is common, references to *ufiti* were mostly found in relation to colonial and religious texts. This study takes the stance that colonial texts have romanticised and exaggerated the ‘religiosity’ of *ufiti* to such an extent that it is seen as a mainstream belief rather than the tool for corruption of societal norms it is. Texts like Mitchell’s below would now call for more rigorous critique:

It is tension within the lineage, which is most closely attended by dire results. The most important reflex of this tension is accusations of sorcery. Good relations among members of a matrilineage are adjured, mainly because friction opens the way to sorcerers. The Yao believe that sorcerers kill their matrilineal relatives so that they may share the flesh with other sorcerers. The sorcerer is a fundamentally wicked person and may kill any relative but is more likely to kill those whom he hates (Mitchell, 1956: 137).

A number of arguable premises pertain here: the sorcerer merely waits for a family cleavage to occur; people act not because they are moral being but because they fear malign forces; and that sorcerers kill to eat flesh. If the first premise were true there would be no need for witch hunts. And if the second were true the *afiti* would be regarded as positive forces. As for the last premise, Breugel came close to providing an

³¹⁹ But Cf. Dijk et al., 2000

answer, although inherently contradicting himself in nearly missing the connection between *ufiti* and the Devil:

All these *ufiti* beliefs are but a reflection of the profound human experience of evil, hatred, greed and envy, as the deepest causes of suffering. The Chewa do not believe in a devil but they do believe in *mfiti* and *ziwanda* (the continuation of a *mfiti* in the hereafter). For them *mfiti* and *ziwanda* are the incarnation of, the personification of moral evil. As belief in the Devil often grows in times of trouble, so among that Chewa belief in *ufiti* increases in times of social stress (Breugel, 2001: 230).

Put simply, *ufiti*, in its classical form equates to the devil. Had Christian missionaries accepted that ATRs had concepts of good (God) and bad (evil/devil), the whole subsequent discourse in which missionaries saw all ATRs as ‘pagan’ or ‘heathen’ devil worship would have been avoided. Their imposition of a Satan/Devil concept, a concept already personified in ATRs by *ufiti*, created an unnecessary distance between *ufiti* and evil. So desirous of this imposition were missionaries that some ‘worship’ of *ufiti* was regarded as mainstream ‘native’ religion.³²⁰ It is also noticeable that Breugel mentions social, but not economic trouble. Social stresses arise from social and economic tension; among the poor social stress is more likely to be due to economics rather than kinship problems often cited by anthropologists (Cf. Kuper, 2000: 132 – 158).

A number of postcolonial observers have examined the *ufiti* phenomenon in Malawi. Kapapa (1979) and Wilkinson et al. (1991) dealt with it from a clinical perspective that saw *ufiti* as part of the belief systems leading to illness. Hopkins (1980) findings have already been critiqued. Chakanza (1985) worked on the phenomenal popularity of witch finding over the colonial and postcolonial periods, while Redmayne (1970) examined the charisma and work of one of the most popular witch finders Chikanga. Marwick’s (1952: 120 – 135 and 1965) work was mostly on the contextual uses of witchcraft within African societies. Englund (1996: 257 – 279) examined the role of witchcraft in how rich people are viewed in some Dedza localities.

Breugel (2001: 212) attempts to differentiate between *mfiti yeniyeni* (true witch), a

³²⁰ I am grateful to Jack Thomson for pointing out recent work in this area, for example Meyer (2000). Theologians, in my view still maintain an unnecessary distance between *ufiti* and Satanism/the devil.

concept which defines ‘something which is believed to exist and is feared but which is essentially a product of the mind, rationalisation by which people explain suffering and which points to evil in men as the cause of such suffering’, on one hand and sorcery, *mfiti m’pheranjiru* (killer by malice) on the other. His differentiation is marred by the fact that *mfiti yeni yeni* translate as ‘true witch’; both therefore are real witches.

From the above works arise the concepts of *ufiti* as variously religion, inherent evil, a psychological social phenomenon and something almost universally believed by the population.

This work builds on the work of these and other observers, including a number of student dissertations examined in Chancellor College library. Unlike most of these uni-modular concepts of *ufiti*, this study views postcolonial *ufiti* as multi-modular:

- A functional reality, in the sense of ability to utilise human agency to poison, used for malign purposes by its practitioners and feared by victims and would be victims, and, even more crucially,
- A social and mental construct that enables some sense to be made of the miserable colonial and postcolonial socio-economic reality of life in Malawi, and
- A discursive construct, resulting from historical precedents, used by believers and agnostics in explaining, delineating, obscuring, attempting some understanding and coping with the dualities, contradictions, ambiguities and deficiencies of postcolonial Malawi.
- This work would contest the idea of an inherent, hereditary form of witchcraft, seeing *ufiti* as purpose driven theory and activity. This theory may be designed for communal or societal control and the activity may involve activities directed towards individuals or more people.

In this work we are more concerned with the theoretical ramifications of *ufiti*, which produce the ambiguities of *ufiti* discourse. Chewa/Chinyanja proverbs contain many of these themes. For example a threat is inherent in the proverb: *Aliwona potuluka, polowa salipenya* (He will see sunrise but not sunset) (Chakanza, 2000: 39). Or the illustration

of extreme evil contained in: *Mwini wake wapha pa mbeu yake* (He has killed his own seed [for witchcraft purposes]) (ibid: 233). A related saying is that by a supposed victim, who usually complains of being *M'bala ndiwo* (the producer of meat [for others to eat]) (Saleta Phiri, 2001).

The discursive aspects of *ufiti* are recognised in proverbs like *Ufiti ndi mawu* (The bewitching is in the words) (Chakanza, 2000: 305). Indeed one of the paradoxes of witchcraft is why such a powerful force is afraid of being seen. *Ufiti* typically is associated with darkness, when most people are asleep or disabled by the darkness. A Chewa proverb recognises this fact and paradox: *Ukatambatamba umapenya kumwamba, kum'mawa kungakuchere* (When you are practicing witchcraft, you look upwards, lest daybreak overtakes you). As suggested in this study, the *ufiti* construct, like the real *afiti*, the malign practitioners who kill others for their possessions using poison, becomes exposed with vision (education) and an improvement in the socio-economic climate (daylight). This developmentalist theme was reflected in the slogan chosen by the nationalist leaders in Malawi and Zambia (the so-called Chewa cultures) *Kwacha!* (It is daytime!), the resonance with *glasnost* is obvious.

In popular musical discourse references to *ufiti*, at the serious, agnostic and light-hearted levels are also common. For example, Enock Evans 1950s *Akapasule* (*Mr Home Wrecker*) warned said homewrecker:

Mwatenga mkazi wanga mwapita naye ku dansi; (You've taken my wife to the dance);
Ndaona nthawi yatha, mukwela pa ndege! (And I see that you kept her late, you will travel by plane!)
Mayo mayo mufera chiani? (Mama mia, what are you dying for?)³²¹

'Travelling by plane' is a euphemism for 'you will die', an oral curse.³²² Evans' apparently genteel and sophisticated song was thus deeply steeped in the sorcery tradition. Alick Nkhata's 1960s *Ndithandizeni mbuye wanga* (*help me my Lord*),³²³ although admitting to consulting, not one but several *ang'anga* (traditional practitioners), for his son's illness, takes a modernising stance: he finds the *ang'anga* to

³²¹ *Zamakedzana* (Golden Oldies), MBC programme 1994 – 2000, transcripts in my archives. *Akapasule* is a popular song on this programme.

³²² After the belief that witches fly at night killing their targets in the process.

be ineffective and only interested in money. He, a poor man, could not afford their dubious services.

5.6.2 Current *ufiti* discourse

During my fieldwork I observed the frequent use of cultural signifiers in ordinary oral discourse; these could be held to have normative functions. For example, there were frequent references to *zaufititu izi* (this is witchcraft) to signify abnormal or aberrant behaviour. Another discernible feature of Malawian public culture, as we saw earlier, is the tendency to avoid some subjects by resorting to what we have termed *ufiti* discourse. This is done, for example by labelling them *zosachulidwa* (things you do not talk about) or by signifying to the speaker, to stop him from proceeding in a particular direction of discourse, that *mutilaulira* (you will provoke the wrath of the Gods). Even in elite circles discussion of *ufiti*, at all levels of the discourse (light-hearted, agnostic and serious) is common. Examples of *Ufiti* discourses may be found among Christian and Muslim groups in Malawi.

In July 2000, one of the most popular songs on the radio was *Mbuyo kucheta* (Out of sight) (Skeremu, 2000). Its lyrics address the paradox of the popularity of *ufiti* discourse:

Inu achinyamata, (You the youth,)
kumbuyo kucheta! (out of sight, out of mind!)
Tikayendayenda tidzipita kumudzi (After some wandering, we should visit home)
Tisamati tikapita moyenda (We should not say, once away from home,)
kumudzi sindifunako; (I don't want to go home;)
adzangondilodza ine! (they may bewitch me there!)
Anthufe tinalodzedwa kale; (We humans are cursed already;)
imfa tingoyenda nayo... (we walk with death all our lives...,)
palibe chozemba ngati imfa... (there is nothing as cunning as death...)(Austin Skeremu, 2000)

The song then goes on to report on what happened at home once the town dweller had left: brother Charles hangs himself, uncle falls out of a tree, and aunt drinks [rat poison], all of which are concrete events not associated, at least in the song, with witchcraft. The song seems to be, effectively, here, exposing the *ufiti* discourse here as

an excuse for not going home, an alibi. In the song the allegation of *ufiti* is not substantiated because all the deaths occur from natural causes, accidents or suicide; the *ufiti* construct is an easy excuse. The song suggests 'we humans are cursed already', not in the fatalistic mode, but to point out that life has a limited span, no one can dodge death. Skeremu uses *ufiti* discourse to de-construct the *ufiti* excuse (Personal interview, 27/7/2000). Yet I found it popular among both those who subscribed and those who did not subscribe to the *ufiti* as reality. For the former, falling out of a tree may be the result of a curse.

That *ufiti* discourse may ascribe sudden unexpected illness to *matsenga/ufiti* (sorcery/witchcraft) has to be seen in this perspective; it may be a literal 'factual allegation' or a coping mechanism. These discourses, which may reflect underlying localised beliefs, are as seen from *Mbuyo kucheta*, often reinforced by the media.

In a climate of worsening poverty and increasing ill health this reinforcement, as we will later suggest, when we examine the use of the media by the government, is a usable tool of governance. From the traditional medical practice perspective, *sing'anga* Kumpolota (Oral interview, 18/7/ 2000) agrees:

There might be more *ufiti* now because everyone now is money oriented. In those days the poverty was not that severe. Now when one has money, money rules the heart.

Kumpolota here refers to the postcolonial poverty, which is difficult to solve given the postcolonial land constraints. The introduction of cash and cash crops in the context of land shortage exacerbates the poverty.³²⁴ Given the view that witchcraft is intended to secure riches and those who stand out as rich in rural communal areas have, historically, sometimes been considered *afiti* (MacKenzie, 1925: 255) this statement is not as illogical as it sounds.

In a climate of inadequate resources, the steep fight, which western health promotion

³²⁴ In a society where barter is used people pay with eggs, chickens, dried fish, tomatoes, cassava and other things. They can therefore afford access to traditional medical services using this method. When the cash system is involved, the process of turning these things into cash can be prohibitive for those with small quantities, which would not be economically feasible to convert into cash. Dr Banda capitalised on the ability of Malawian peasants to donate eggs, beans and other crops in the construct of his patronage system (Lwanda, 1993). See Chapter Six, (6.1) for more discussion of poverty due to land shortage.

methods have against prevailing and vibrant traditional attitudes is also evident in the media. When Chrissie Chirwa, a psychiatric nurse, stated that she saw mental illness as being caused by stress, social problems, unemployment, congenital problems, drugs, cannabis, heredity and other problems, *Sing'anga* Chechere Friday gave another viewpoint. The *Sing'anga* was quoted as stating that on top of all the things the nurse was mentioning mental illness does also result from *kulodzedwa* (being bewitched), the transgression of prescribed methods of achieving *kukhwima* (fortification) or achieving richness (Mussa, 2000).

This compromise from the traditional practitioners, acknowledging a dual causality, is particularly important in the HIV/AIDS debate; school students may be socialised into believing that you can get ill both by being bewitched and through germs. They may equally be socialised into believing that one can protect against illness. This may, in a small part, explain some of the observed 'risk taking behaviour' (Cf. McAuliffe, 1994).

The reality or non-reality of *ufiti* can best be illustrated by using social constructionism theory (Gergen (1985) or the related constructivist realist theories as explicated by Cupchik (2001: 1):

Constructivist realism is proposed as an alternative ontology that accommodates positivism and constructivism and the methods that they subtend. The first step is to acknowledge a social world (or worlds) that is reflected in the natural attitude of daily life and exists prior to and independent of either positivist or constructivist analysis; hence realism. Phenomena are understood as processes, which cut across the physical, social, and personal (self) worlds.

In this light the quantitative (realist) and qualitative (constructivist) approaches used in this study become complementary. As Fielding et al. note (2001: 3)

[this] reality is not a given, but it is constructed by imbuing the phenomenon in question with meaning... If this meaning is socially shared, the process of meaning construction will hardly be noticeable; the more discrepant the social realities of two persons, however, the less they will be able to agree upon the reality of a phenomenon.

It will be noted, first, that in the Malawian context, orality helps reduce discrepancy.³²⁵ Second, that the possibility of discrepancy between the elites and rural people is reduced by the utilisation of culture as a shared adhesive tool. Third, one construction of *ufiti* can be illustrated by using an example from musical discourse.

Bambo Mingi anapita kwa sin'ganga eh! Kufuna chuma eh!
(Mr Mingi went to the witchdoctor! He wanted to get rich!)
Asin'ganga anawauza eh! Akaphe mayi wao!
(The witchdoctor told him: go and kill your mother!)
Bambo Mingi pakuyamba misala eh! Anabvomela!
(In a fit of madness, Mr Mingi agreed!) (Malawi Police Orchestra, 1988).

In this construction, although this musical discourse recognises the reality of *ufiti* as discourse and practice, the standpoint of the composer is that it is an irrational (*misala*) one.

Having outlined some of the theoretical, functional and discursive aspects of *ufiti* I would like to demonstrate how governance in Malawi, utilising the state monopoly of the largest broadcasting station, uses *ufiti* and *m'vambo wathu* discourse to reinforce the coping mechanisms of the rural and urban poor, particularly in relation to disease and deaths due to HIV/AIDS and other illnesses.

The Malawi Broadcasting Corporation (MBC)

The Radio is the most penetrating medium in Malawi. Apart from several small district-wide religious and secular broadcasting stations catering to mostly urban areas, the MBC was, until 2001, the main broadcasting organisation. In 2001, I found that Radio Maria, the Catholic Church's radio station had become a smaller, but significant competitor.³²⁶ I therefore monitored the MBC for cultural programmes relevant to this study. One of these is a nightly news programme called *Nkhani za m'maboma* (district

³²⁵ Using the hegemonic oral culture of controlled broadcasting, for example.

³²⁶ Radio Maria offers news, religious news and church services, gospel and church music, as well as popular music with positive social messages acceptable to the Catholic Church, such as pre-marital sexual abstinence. The majority of the people I asked, including some Muslims, liked Radio Maria's popular musical content and its lack of extended political coverage.

news), which is usually broadcast at 9 pm. To enable a clearer understanding of this section's underlying thesis of a socially constructed *ufiti* discourse it is necessary to give examples of some of *Nkhani za m'maboma* contents, Box 1.

Box 1 Edited transcripts of MBC *Nkhani za m'maboma* programmes.

Tape One (MBC, 27/6/2000)

A *sing'anga* who tried to kill a charm belonging to a Mulanje witch residing in an Mzuzu suburb had to resort to biting the live charm (said to resemble a grasshopper, but with an aeroplane engine at its front end) after failing to drown it in water. The owner of the charm stated that he had obtained it from Sapitwa, in Mulanje. The *sing'anga* had been invited to witch find by the suburb headman.

Tape Three (MBC, 29/6/2000)

A *sing'anga* has been arrested and charged with murder for giving *mwabvi* (witch finding by ordeal) to a suspected witch who died.

Tape Four (MBC, 3/7/2000)

A grave robber admits, in court, to stealing a child's body. His aim was to use it to produce *zidzimba za business* (charms that ensure success in business), in an effort to make his business successful. He had removed the corpse's head and the covering linen.

Tape Six (MBC, 15/7/2000)

An Nkhata Bay man admits to sexually molesting a 3 year-old child. Magistrate Bester Phiri sentences him to 5 years with hard labour as, 'there are too many of these cases now'.

Tape Seven (MBC, 20/7/2000)

A previously wealthy man who lost his job because of his own corruption was stripped of all his wealth, leaving him dependent on his wife. He tried to get another job without success. His wife kept her job, house and money. As time went on he became very jealous of the wife, imagining she was going to leave him for other men. In an attempt to keep her love he went to a *sing'anga* who gave him a portion to apply to her clothes. The wife caught him in the act of applying said potion.

Tape Eight (MBC, 22/7/2000)

a) A woman is discovered *akukatamba* (dancing at night in a manner associated with witchcraft). b) A pig is found to be stealing cassava; when it is eventually killed a *chithumwa* (charm) is found in its stomach. On the same night that the pig is killed an old woman dies, and the cassava stealing stops. c) A patient's abscess is lanced and a small *chule* (frog) leaps out of it. d) A girl who had been thought dead is found alive working as an *ndondocha* (zombie) in a maize mill. A positive *sing'anga* restores her ability to talk. d) The owner finds (in a dead rat's mouth, at her brother's house) a set of long lost keys.³²⁷

Tape Nine. (MBC, 23/7/2000)

a) A woman whose snake was killed cries for it. b) A Chitseka (Lilongwe) *Sing'anga* removes various *ufiti* charms from a businessman who had gone to him seeking *ufiti* for riches.

As is illustrated, this programme features frequent stories of magic, witchcraft or other

³²⁷ Here the rat is assuming the role of a *fisi*, who steals in the night.

mystical occurrences among the usual offerings of fights, thefts, births and other normal news. In a six to ten items bulletin one or two items may be on *ufiti* or *matsenga* (sorcery), or the breaking of sexual taboos. As if to underline the programmes legitimacy, major commercial firms, including banks, sponsor these programmes, whose contents are varied. This very popular programme reports these anecdotal events in a matter of fact manner that gives credence to these difficult to prove reports. It is popular with many rural, urban, rich, poor and educated Malawians. It is even followed by Malawians in the diaspora via the Internet. And, interestingly, the State President Bakili Muluzi had earlier indicated that this is his favourite programme (Personal communication, unattributable, 2000). He was later to admit this in a public forum in a jokey but factual manner on 26/7/01, following the defeat of the South African football team by the Malawi *Flames*:

The game was so important that according to *Za m'maboma* ... [laughter from audience] ... Yes, I listen to *Za m'maboma* at nine o'clock... [more laughter] ... according to *Za m'maboma* a certain man in Chief Chikowi's area in Zomba had to sell his wife's goat and bought a radio to follow the [football] game.³²⁸

Whether one actually believes the events or not is not the point here. The mystique and construct created on society to explain and order things, is the point. For example, the State President has himself used the construct on the opposition. On 6/7/01, at the Independence celebrations he threatened 'trouble making' opposition leaders with '*ndege zopanda mapiko*' (aeroplanes without wings) (Cf. Kayambazinthu et al, 2000). Whether this was a reference to jet fighters, of which the Malawi Army has none, or whether this was used as a metaphor, akin to Enock Evans *Akapasule* was hotly debated. The threat was interspaced with UDF *mbumba* singing '*Amuluzi amenewo! Kumtunda!*' (That's our Muluzi! The High Authority!)

We therefore note here that the state as governance attempts, despite its developmentalist and progressive stances, to utilise *ufiti* and *mwambo wathu* (our culture) discourse when opportune. Unfortunately, in the medical arena of HIV/AIDS these discourses can subvert health promotion messages.

³²⁸ Speech in my archives given on 26/7/01, on the inauguration of the Malawi Sports and Culture Foundation, Blantyre Mount Soche Hotel.

Another communal or societal aspect of *ufiti* discourse is seen where the need for order exists. This imperative to maintain order without policemen, messengers, Young Pioneers or soldiers has, as we demonstrate promoted *ufiti* discourse.

Case study 1: Roadside merchandise safety.

One of the descriptors of law and communal order is the safety of merchandise, which is usually left on the roadsides of Malawi. Malawi governments used to pride themselves on the friendliness of its people, and President Muluzi, like Banda before him, speaks of *bata ndi mtendere* (peace and freedom). In times of communal tension and lawlessness, as witnessed during *Operation Bwezani*, or elsewhere in Southern Africa, one sees less of these goods on roadsides.³²⁹

I set out to investigate people's opinions on why roadside merchandise did not often get stolen. I tested the *ufiti* discourse by assessing how the power of *ufiti* keeps roadside order. My informants all stressed the various ways in which *ufiti* is still alive: roadside stalls with, by Malawian standards, expensive goods, left unattended. According to Mike Lwanda (Interview, 3/8/2000), a secondary school teacher,

Those who would steal are dissuaded by the power of *ufiti*. Those who do steal will find that on arrival home the bundles of charcoal had turned into skulls, excreta, or dead bodies, on being returned to their owners the goods turn back to charcoal.

Mr. Tembo (Interview, 29/6/200) also gave the *ufiti* version.

No one can touch these goods; the owners have protected it with witchcraft.

³²⁹ During *Operation Bwezani*, elements of the Malawi Army rose against Dr Banda's paramilitary Malawi Young Pioneers, against the wishes of their superior officers, following a brawl between the two organisations in Mzuzu during which a soldier died. Subsequently the Army high command sanctioned the operation and totally disarmed and disbanded the organisation. *Operation Bwezani* was one of the most important steps in the process to reduce Dr Banda's paramilitary powers. Tengatenga defends the operation, from a clerical point, as a 'Good Friday before Easter... a necessary path to national reconciliation' (1995: 108).

All the taxi drivers, some of the most travelled people within Malawi, I asked about the leaving of thousands of *kwacha* worth of merchandise on the roadside almost unanimously felt that stealing the goods was impossible, as they were protected by *matsenga* (magic). Mr Kasusu, a Zomba taxi driver (Interview, 26/7/00), offered a more considered answer on the issue of roadside merchandise: he attributes it to a mixture of 'the fear of *ufiti*' (which would explain why roadside food merchandise is rarely stolen amidst such hunger); the fact that some goods, like pots and firewood, are bulky to carry; and the fact that some goods are not 'worth stealing, as you would have to carry such a lot to make it worthwhile'.

Thus in terms of the maintenance of order, *ufiti* discourse still serves the same role as in colonial and pre-colonial times; it is a construct that in its reality, implied reality or threat, helps preserve communal order and, in this case, the mental health of roadside vendors. It is also a construct that, given the socio-economic conditions of rural and peri-urban Malawi, remains a useful tool for both central government and the chiefs in maintaining order.³³⁰ The role of *ufiti* discourse in maintaining order is internalised and becomes accepted, to varying level of belief. This aspect of its utility can be squared with its role in diluting western health promotion messages, particularly HIV/AIDS awareness, by taking into account the vested interests of traditional practitioners, central governance and the western health promotion practitioners who ignore the possibility.

From this implied constructional possibility of *ufiti* we turn to another way of demonstrating the power and reality of *ufiti*. This is by the demonstration that it actually exists. Witch finders activities demonstrate this, as in colonial times. In pre-colonial and colonial times *mwabvi* ordeals, where the suspect was made to drink a poison made from the bark of the *mwabvi* (*erythrophlaeum guineense*) tree at an *nthando* (the place of the ordeal) were some of the visible signs of *ufiti* presence (Cf. Marwick, 1965: 87 – 88; Breugel, 2001: 218 – 222). In colonial and postcolonial times the ordeal is less publicly used for legal reasons. I did not find a recent episode I could corroborate. However, the acts of protecting oneself against witchcraft using, *kukhwima*

³³⁰ For example the inadequacy of the police to maintain rural and peri-urban law and order.

(fortification) and the acts of protecting houses and other places with *mankhwala* medicine are suggestive of a reality; as are the public manifestations of purification or cleansing societies of *afiti* using *mchape* (the cleanser). Another aspect of life, which suggests the reality of *kukhwima*, is the association of riches or success among some with *ufiti* in the view of some members of the public. Beliefs that some successful maize mill owners put parts of dead people (whom they had commissioned to be killed) in the mill engines were still current in my childhood both in Nkhota Kota (1958 – 1961) and Malindi (1961 – 1964) (Cf. Breugel, 2001: 226). In 2000 and 2001, I found similar allegations directed at powerful people *achikulire*. Interestingly, these are impressions which the *achikulire* themselves are anxious to promote.

These public demonstrations are witnessed by students and may become internalised experiences in the form of discourse or belief/fear. I here give an example of a community witnessing the perceived reality of *ufiti*.

Case study 2: Chief Chindamba and the *ufiti* at Malindi.

At the beginning of my fieldwork in July 2000, I found that a witch-finder had arrived at Malindi. I set out to discover how and why this had come about. Eventually, a complicated saga involving *ufiti*, disease, an excess of deaths, politics and legitimacy unfolded.

Malindi, like Likoma, a home of the Nyanja, is an enclave of Anglicanism; but unlike the latter it is an enclave within a Muslim and predominantly Yao area. The strong Muslim and Christian community is an unlikely source of so many apparent *afiti*.

The witch hunt apparently began when the previous Chief Chindamba became unpopular following the accumulation of a number of reasons, including: his alleged sexual and verbal abuse of women, his selling of a plot of land to a European who wanted to build a holiday cottage in the village,³³¹ and, his alleged suspected and

³³¹ This is a complicated charge. The Muluzi government has persuaded the Chinese (ROC) to build an all weather road from Mangochi to Makanjira. In anticipation of this opening up of the eastern shore of the Mangochi Lake Malawi speculators (Asians looking for property investments and cottages,

unspecified witchcraft activities.³³² It is also important to note that there was an added legitimisation that this Chief Chindamba was not of the original true line. He was, with official government approval deposed and banished to his home Bala, ten miles away.³³³

The UDF government then installed a new chief, Maere, who had been, between 1992 and (certainly until I left Malawi) 1995, a prominent and hardworking UDF activist.³³⁴

In 1999, one of Chief Maere's early assessments of the Chindamba/Malindi, perhaps a reflection of his perception of the prevailing socio-economic environment, was that there were too many *afiti* causing a lot of suffering: illness, deaths and souring social relationships. He decided to do something about it and discussed the problem with his counsellors and prominent Chindamba *achikulire* (patriarchs). They agreed with him that it was necessary to remove *afiti* from Malindi. A number of these prominent *achikulire* were then asked to contribute funds to secure the services of a good witch finder. A number of them did, including some highly educated elite.³³⁵

By April 2000, Adini was installed at a house on the roadside. The site was a rented house with a sizeable front yard. A flagpole with the UDF party flag was erected and a dead bird, apparently a hawk, was attached to the middle of the pole. This hawk symbolised the all-seeing power of the *sing'anga* Adini. The UDF flag effectively represented the authority of the new chief, the apparent authority from and agreement from the party and government to conduct a witch-hunt and, the chief's difference from

Malawi elites looking for lakeside cottages and land and Europeans looking for retirement cottages) are buying land very cheaply from 'poor' cash strapped chiefs, in breach of customary land laws. Local villagers heavily resented this.

³³² See Mitchell (1956) for the role that accusations of witchcraft may play among the Yao lineages.

³³³ The previous chieftaincy had been altered by Dr Banda's regime, in the 1970s)

³³⁴ He was one of my UDF colleagues in 1993 – 1994. He is a quiet contemplative man with a 'big social conscience'. During my association with him, I placed him on the social democratic wing of the UDF. He was keen on social changes that improved the status of Mangochi East, which, due to the intervening Shire River had not benefited from as much exploitation by tourist and other industries as Mangochi West.

Some observers maintain that the new transitional pressure groups (the United Democratic Front and Alliance for Democracy) were, after 1994, after activists like Maere had been supplanted by newer entrants, subsequently hijacked and populated by many 'opportunists', both ex-MCP and new politicians, drowning out the original reformist and social democratic activists. Most of these alleged 'opportunists' were businessmen.

³³⁵ Some with tertiary education.

the previous (allegedly) pro-MCP chief. As well as witch finding Adini engaged in individual casework, seeing patients for a variety of ailments.

His witch finding sessions, a mixture of ritual, threat and entertainment, were usually held in the afternoons. A public address system was installed and Adini would firstly ask people to bring their *zithumwa* (totems and charms) voluntarily. If this did not work, he would challenge those that did not bring these by a certain date to do so, threatening to come and find them. Many surprisingly brought their *zithumwa* voluntarily. In a confirmation of the duality of Malindi culture, a number of those who volunteered their *zithumwa* turned out to be prominent church or mosque attendees. Sometimes he would indicate where someone's *zithumwa* were. When I wondered what happened to those who were fingered as witches but did not surrender their *zithumwa*, my cousin, Asili, stated that a number of those fingered as witches but who declined to bring his their *zithumwa* still faced the stigma of being witches:

The record will have stuck. It is up to the person to go and clear himself or admit their *ufiti*.

Asili also clarified, or rather gave me an insight into one of the ways in which witch finders succeed. Adini fingered one of my relatives, a former medical assistant, as an *mfiti*. As soon as this happened, this former medical assistant had disappeared from the area, seeking refuge in Namwera. On inspection of his bedroom, a charm, which I videoed, was discovered under his bed.³³⁶ In this man's case the *chithumwa* was not a surprising finding, despite his good record as a competent western medical (assistant) clinician, he had used *ufiti* discourse on a number of occasions when family matters involving resources and power had been discussed.³³⁷

From my observations, Adini's intervention in the area provided an apparently much needed temporary respite from the problems of poverty, disease and death. The talk was of how prominent citizens were turning out to be *afiti*, in this case bad, selfish *afiti*, whose motives were self-improvement at the expense of others. The villagers I spoke to were mostly of the opinion that their lives would improve once the *afiti* had been

³³⁶ This was not in fact a bed he was entitled to by rank, but had appropriated by force of personality.

³³⁷ Specifically he wanted to appropriate the land and house of his dead uncle.

removed. Maere's authority was undoubtedly, if temporarily, improved by the episode.

For our study, however, it was the witnessing of this witch finding episode by both St. Martin's Primary and St. Michael's Secondary School students that is worth further comment. The witch finding exercise was not reflected in the questionnaire responses. In the FGD with the pupils at St. Martin's pupils it was one of the three main issues identified, and yet only 16% of the St. Martin's and 10% of St. Michael's College admitted to an awareness of *ufiti*. And yet these students witnessing adults confessing to *ufiti*, handing over their charms under the presence of village authority and national symbol (the flag) must have internalised aspects of the *ufiti* discourse, which may form their future views of the phenomenon. On direct questioning only a minority admitted to knowledge of *ufiti*.

Given that, in the case of the Christian community, some prominent members of the congregation were found or confessed to be *afiti*, the ability of village-based education to erase these messages completely is debatable. The witnessing of witch finding by students gave the *ufiti* discourse in the area a boost, as shown by the St. Michael's girls who mistook me and my driver for witch finders. *Ufiti* was no longer just a theoretical concept, but, for some of them, had been made real. One of the prominent Anglicans, who had been fingered as *mfiti* by Adini, was noted to be going through a 'born again phase' at the Anglican Church, a symbolic rejection of malign forces.

The Adini incident proved that authority figures could still resort to *ufiti* discourse to make up for any deficiencies in the services affecting their population. It was clear that the Adini incident had a profound effect on the nearby school. In a brief focus group discussion before they started filling my questionnaires St. Martin's pupils rated 1) Malaria, 2) Edzi and 3) *ufiti* as some of the main problems in the area.

Interestingly, perhaps reflecting the subtlety of these experiences and the involvement of other dynamics, their quantitative figures seem to underestimate their awareness of *ufiti*. But in selecting the two top killer diseases and a topical cultural issue, the primary school children demonstrated their knowledge of socio-medical issues. Their first hand experience of a witch finder is likely to have made as great an impact on Malindi

school children as did Chikanga in Nkhota Kota in the 1960s among those of my generation and Mchape at Liwonde in 1995 among my then medical students, an impact that may be reflected in their future attitudes to traditional and western medicine.

It can be seen therefore that *ufiti* discourse can be appropriated and used in reality and by suggestion at a personal, communal and national level. In this way *ufiti* discourses are useful tools in the attempts to normalise and contain both behaviour and expectations, whether cultural, political or, indeed, sexual and medical.

5.6.3 Qualitative and quantitative survey results on *ufiti*

Having set an example of a localised incident involving *ufiti* discourse I now present the results of my respondents answer to the Question: Do you think/believe that *ufiti* can cause the following: rheumatism, malaria or HIV/AIDS? (Table 17). Here (Table 17), it is seen that only a minority, but a minority that ranged from 13% to 33% thought *ufiti* could cause rheumatism, the disease traditionally associated with *ufiti*.³³⁸ Between 05% and 20% thought *ufiti* could cause malaria; and between 00% and 14% thought *ufiti* could cause HIV/AIDS.

There were, looking at the table, very few students who thought that *ufiti* could cause HIV/AIDS. There was no discernible rural/urban, and indeed age or educational, dichotomy in the responses.

H. M. age 15, form 3, St Michael's Girls secondary School (781): 'I don't believe in witchcraft although I hear people talk about it. I do not think HIV/AIDS and Malaria can be caused by witchcraft'.

If we take these responses as indicating belief, we can confidently state that science was being learnt.

However if we take into account the concept of localised knowledges and dilution of health promotion messages from *ufiti* and other discourses, then the 10% of senior

³³⁸ *Nyamakazi* (rheumatism), with its 'body pains', 'muscle pains' and morning stiffness has all the hallmarks of a disease arising from a nocturnal 'beating' or 'working over' by *afiti* (witches).

theologians or 14% of St. Martin’s respondents who thought *ufiti* could cause HIV/AIDS becomes problematic both in health promotion terms and the perpetuation of *ufiti* discourse.

Table 17

Question: Do you think/believe that <i>ufiti</i> can cause the following: rheumatism, malaria or HIV/AIDS? ³³⁹ (All figures are in percentages).						
	Rheumatism		Malaria		HIV/AIDS	
Site:	Yes	No	Yes	No	Yes	No
Primary:						
St. Martin’s n=43	20%	43%	20%	51%	14%	55%
Bwaila n=61	16%	67%	10%	72%	05%	71%
Secondary:						
Mangochi n=15	20%	67%	00%	97%	03%	93%
St Michael’s n=202	19%	37%	11%	60%	05%	62%
St. Mary’s n=21	31%	52%	05%	83%	02%	86%
Masongola n=18	22%	78%	11%	89%	00%	97%
Zomba Cath. n=16	25%	67%	06%	78%	06%	81%
University:						
1 st Year Ph. n=60	13%	65%	06%	78%	02%	79%
1 st Year Eng. n=98	20%	69%	12%	79%	05%	85%
2 nd Year Biol. N/A						
2 nd Year Th. n=12	33%	58%	08%	75%	00%	92%
3 rd Year Th. n=10	20%	60%	20%	70%	10%	70%

That few believed in *ufiti* as causative of HIV/AIDS thus becomes worth noting as the fact that even among these elite students such beliefs should persist at all. This was qualitatively expressed as:

E. M. age 14, St Michael’s Girls Secondary School (766): Yes
[witchcraft can cause rheumatism’

³³⁹ Here only the Yes and No answers are given. Those who did not answer this particular question make up the difference between the total of these and 100%.

Similarly the part played by *ufiti* in causing disease elicited widely differing views, ranging from the agnostic:

F.M., age 17, Form 4, Zomba Catholic Secondary School (404): 'I don't know'.

to those with certain convictions

B. P. M. age 20, form 3, Mangochi Secondary School (315): [yes *ufiti* works as] some diseases are not cured at hospitals.

And some were so sure that they could not be more emphatic:

Anon, Second year Theology, Chancellor College (13). 'Witchcraft really exists and no doubt about that'.

These minority responses in the power of *ufiti* to cause these diseases can be viewed as the quantitative aspect of the still present localised causality beliefs. It is significant that rheumatism, the disease often associated with *ufiti*, has as one of its cardinal features morning stiffness. This is suggestive, for those who believe in *ufiti*, of a night spent at the mercy of the *afiti*. Among those of my students who completed the qualitative questionnaires this experiential aspect was not usually present but some students were nevertheless confident, a confidence based on varying degrees of evidence. Some apparently had none:

Kachigayo, K. Bwaila Primary school, (471): 'I do not know [what *ufiti* is for, but] 'yes, *ufiti* works'.

Others cited communal behaviour and 'evidence'; evidence always referable to certain communities and behaviour:

K. C., Std 8, Bwaila Primary School, (472): '*Ufiti* happen[s] with people like us... it is done based on behaviour... a certain friend [said] that his mother was killed through *ufiti*'.

Anon, Biology Chancellor College (280): [I think *ufiti* works] through evidence in the villages.

In some personal evidence and experience was quoted:

Anon, Biology, Chancellor College (281): 'I know [*ufiti* works. There is] lots of evidence. 'I am protected [against] witchcraft.
Mwale, M., Std 8, Bwaila Primary School (473): 'Because I saw it'.

And crucially, for this work, was the frequent association of death with *ufiti*, a factor attested to by some of the respondents:

Matador, T, age 16 Zomba Catholic Secondary School (387), 'bewitched people never get better'.
Chirwa, F. M., age 29, Teacher and Patron of AIDS Club, Bwaila Primary School, [they] 'destroy the life of other people... many are dying because of [*afiti*]'

Some students gave the reality of *ufiti* the benefit of doubt, resorting to the 'possibilities' argument. In effect they were using *ufiti* discourse itself to create or perpetuate ambiguity:

Anon, Second year Theology, Chancellor College (24): 'There are a lot of ways of doing *ufiti*'.

Ultimately, the perceived power aspect of *ufiti*, a power that affects nature itself and controls others, was cited as evidence. It was also a power that could be counteracted.

Kilowe, P, form 2, Zomba Catholic Secondary School (371): 'For them to fly at night and stop rains from falling. When there is no rain [an] herbalist helps for rain to fall...'

From quantitative and qualitative angles *ufiti* is seen in a negative, but powerful light. Interestingly (Table 18), only a few subscribed to the superstition theory when asked: Do you happen to know what witchcraft is used for?

Table 18 first and foremost confirms, using categories generated by the students themselves, that *ufiti* is viewed as a malign force, and not as a religion.

The students cited jealousy, to make others suffer and to kill, personal pleasure, self-defence, the ability to make one rich at the expense of others by making them suffer as the reason for *ufiti*. The only 'positive' response was that it was used for 'protection' or 'self defence'. None of these can be seen as a religious attribute.

Table18

Do you happen to know what witchcraft is used for? (All figures are percentages)

Horizontal columns total 100%

		Jealousy Please Self	Superstition nothing Hereditary	Protect self	Get Rich	Kill others	Don't know	Make others suffer	No answer
Primary:									
S/Martin n=57	02	05	00	16	00	04	28	12	33
Bwaila n=33	00	00	00	00	00	27	46	06	21
Secondary:									
Mangochi n=42	07	02	00	02	00	07	22	07	53
S/Michael n=59	05	04	00	03	00	00	15	05	68
M/ngola n=32	13	13	00	09	03	03	34	09	16
Zomba C. n=39	00	08	03	08	13	11	13	05	39
University:									
1 st Y Ph. n=14	00	00	00	07	07	07	07	00	72
1 st Y Eng n=33	06	00	06	00	03	09	03	12	61
2 nd Y Biol n=23	09	13	09	04	00	00	09	13	43
2 nd Y Th. n=21	14	00	05	14	05	10	00	14	38
3 rd Y Th. n=10	10	00	00	10	30	00	10	00	40

I was struck at how the issues of poverty, societal norms, money and *ufiti* are interwoven. In their qualitative responses, many of my student respondents saw *ufiti* in terms of a tool that either facilitated the accumulation of wealth or removed wealth from others. When asked: Do you happen to know what *ufiti* is for? The qualitative replies included:

- Anon, Second year Biology Class, Chancellor College (272): ‘Malice, vengeance and leisure’.
- G. N. age 17, St. Mary’s Secondary School (80): ‘Some do it to get someone killed and get his possessions’. ‘Because when one dies I hear ‘its X who [has] probably put a spell on the deceased’.
- M. H., form 1c, St Mary’s Secondary School (79): ‘Because I have seen people dying mysteriously in the villages because of maybe buying a new thing’.

A. Y. form 2, Mangochi Secondary School (345): ‘Some steal food from their fellows magically’

Anon, age 16, form 2, Zomba Catholic Secondary School (386) ‘Those who practice [*ufiti*] become rich’.

Katundu, P., Bwaila Primary School (468): For ‘killing people without robbery’.

Chirwa, F. M. Teacher and Patron of AIDS Club, Bwaila Primary School, *Afiti* ‘destroy the life of other people’, ‘many are dying because of [*afiti*]’

Anon, Biology class, Chancellor College (276): [*ufiti* works] I was once haunted’ [*Ufiti* is used for] fortification, food, riches, wealth.

Kilowe, P, Form 2, Zomba Catholic Secondary School (371): For them to fly at night and stop rains from falling.

Magaleta, C, Bwaila primary School (467): ‘To have a good business’.

And, as above, a significant proportion of those who gave a reason saw *ufiti* as being caused by:

Nansambo, R, form 3, Zomba Catholic Secondary School, (365): ‘Jealousy’.

Here, the motive for *ufiti* is seen as inherent malice, selfishness or material accumulation at the expense of others. This need to destroy others to appropriate their wealth implies either restricted resources or that *afiti* are too lazy to find new resources. The association between richness and *ufiti* must be viewed against the communal nature of most of pre-colonial, and rural colonial and rural postcolonial Malawi.³⁴⁰

Hence when ‘richness [is] achieved without education’ or when the accumulative process is not clear to observers, *Ufiti* discourse is resorted to:

M. G., St Michael’s Girls Secondary School. (735): Because some people are rich since they are not educated’.

The qualitative responses indicated that there were some who recognised *ufiti* as a construct:

Matador, T., age 16, Zomba Catholic Secondary School (387). ‘The belief that there is witchcraft also harms’.

³⁴⁰ Colonial observers suggest, by default, that communal societies were highly suspicious of the rich. As Mackenzie (1925: 255) observes: ‘Prosperity in another arouses all the evil passions of witches and wizards. But [prosperity in itself] was, until lately, not evidence that the [rich person was a wizard]’.

Thus the *ufiti* construct that - as we argued in Chapter Two, arose from the corruption of normative taboos and conflicts amongst resources, personal need and communal order - is still interacting with the resources and poverty substrate of postcolonial Malawi.

But, in this triangulated study, the low quantitative positive responses to beliefs in and the power of *ufiti* sit uncomfortably with the perceived universality of *ufiti* beliefs and the findings from the qualitative survey. But this is an expression of triangulation bringing out, as we show later, the multiple realities of the *ufiti* discourse. The low responses here have to be taken in their context: elite, largely Christian schools, students in this setting acutely aware of the science/*ufiti* dichotomy, students aware of the researcher's background, students' perception of the questionnaire as an examination and students reluctant to answer direct questions on the subject of *ufiti* (Cf. Mwale, 1977: 152 - 157). These problems were minimised by the use of several different questions in the questionnaires, which ensured that students approached the questions from different angles and perspectives. Thus questions approaching the subject like 'Do you happen to know what *ufiti* is used for?' and 'Do you think/believe that *ufiti* can cause the following: rheumatism, malaria or HIV/AIDS?' were used.

5.6.4 Conclusions

Most analyses of *ufiti* or witchcraft in Central and Southern Africa emphasise what is usually termed the religious aspect of *ufiti*. We have argued in Chapter Two that *ufiti* arose from corruption of the societal rules. In this survey none of the students cited it as a religion. The majority saw it as a malign force. It is a tool, a very useful tool, of the malign, an anti-developmental tool and an alibi of the elites in their attempt at accumulation at the expense of the poor. It is an anti-developmental tool in the sense that the battles between the elites and the poor using *ufiti* (Cf. Geschiere, 1997) utilises the same pattern as noted by my student respondents to 'steal food from their fellows magically'. Unfortunately the hardworking cannot now migrate to pastures new to compensate for their losses.

School going students may experience *ufiti* as the 'jealousy' of their peers who are unable to get education. They may be involved in being fortified to counteract this

‘jealousy’. This fortification may be formal, involving scarification or informal using *kukhwima* discourse: ‘You are protected, and have nothing to fear’.

These trends in the *ufiti* discourse suggest that Malawi rural and most urban areas still have significant communal cultures, where excessive wealth may be viewed as wrong or incongruous.³⁴¹ In these cultures, illness can be held to arise from *ufiti* rather than other causes, even when these other causes are recognised; the *ufiti* reason may be more socially acceptable. Given this scenario, it is sometimes felt possible or necessary to immunise oneself via *kukhwima* to ensure success in business or self-protection from enemies.

In previous sections we noted that most students are largely aware of the western scientific causes of diseases like HIV/AIDS, malaria and rheumatism. This scientific recognition is overwhelming but did not entirely exclude *ufiti* causality with certainty for some of my respondents. There was always the *ufiti* possibility:

Nansongole, M, Teacher, Bwaila Primary School, (427): [Witchcraft could] possibly, yes, cause HIV/AIDS.

K. age 13, form 2, St Michael’s Girls Secondary School. (837): ‘It is possible for malaria to be caused by witchcraft but it is not usually caused by witchcraft.’

While agreeing with Marwick’s role of the social importance of *ufiti*, this study takes issue with his failure to emphasise the economic rationale for *ufiti*. This statist and slightly romantic notion also spoils the otherwise useful analyses by Ranger (1972; Ranger and Weller, 1975)), and others who see *ufiti* as one of Africa’s symbolic expressions of ‘confrontation with evil, meaning and competition in a context of rapid social and political change’ (Binsbergen, 1998: 1- 18). We argue that, while these observers concentrate on social change within a persisting rurality, we see significant and culture changing social change as only occurring in the event of significant socio-economic change.

The further suggestion that *ufiti* has been ‘appropriated and virtualised by African

³⁴¹ The elite may legitimise their wealth via patrimonial networks straddling the rural/urban divide.

middle classes and elites in their struggle to create meaning in modernity and postmodernity' (Binsbergen 1998:17) misses the point that *ufiti*, a tool of malign and selfishly accumulative desires cannot be equated with modernity. *Ufiti*, like other malign forces, cannot be claimed to define 'the moral and productive order' (ibid), particularly in the colonial period. In some anthropological and theological analyses, *ufiti* seems to have become associated with mainstream African Traditional beliefs. Most early colonial Malawian texts do not suggest this; in fact Johnston implied the opposite:

The witch or wizard, *mfiti* – as opposed to *sing'anga*, the doctor, the medicine man – is the terror of the Central African Negro community (Johnston, 1897: 446.

The witches were associated not with positive worship, but occult forces.

My survey results would suggest that, in Malawi in general, there is no lack of understanding, despite the limited educational facilities, of scientific concepts among those with at least primary school. The elite who use *ufiti* discourse are by and large, extremely well educated both by western and African standards. Binsbegern is correct where he sees competition and evil, as factors in *ufiti*, but we differ from him where he sees *ufiti* as decontextualised; the context remains largely the same although the scenery and dynamics may have changed slightly.

Geschiere and others have, perhaps in more acute forms, described the state power aspects of *ufiti* for the Cameron (1998). In this study we have noted how in Malawi power players largely use *ufiti* in the discursive model, to maximise suggestion, protection and ensure subjection. Of course some use it for real.

A better understanding of *ufiti* is obtained by balancing the quantitative results with the qualitative. These show *ufiti*, both rural and urban, as residing in orality. In both settings and contexts the same forces nourish *ufiti*: poverty, limited resources, power conflicts, and suffering inexplicable by science or religion, whether Christian, Muslim or African Traditional.

And finally, although only a tiny proportion of my student respondents saw *ufiti* as causing HIV/AIDS, among them and the general population, for a variety of reasons, HIV/AIDS is the *ufiti* disease par excellence. HIV/AIDS is of mysterious origins, of contested ownership, spreads mysteriously, has a 'symbolic prevention' via condoms, is governed by multiple religious and moral perspectives (Cf. taboos), has an association with bodily fluids and reproduction and death, has a levelling ability (the early death of the poor and the higher death rates of the urban elites), and lacks a medical cure. HIV/AIDS and *ufiti* discourse thus resonate, if they do not exactly relate. Given, the foregoing, *ufiti* discourse is, not surprisingly, frequently recruited for HIV/AIDS explanations.

Ufiti discourse is therefore harmful to HIV/AIDS prevention at three levels. First, it dilutes and confuses the positive anti-HIV messages. Second, it gives politicians an alibi for not doing more in the western medical sector by exploiting the traditionality dynamic (see Chapters Six and Seven). And third, by further exploiting the traditionality dynamic the elite, like the colonialists, are able to contain and control the expectations of the *anthu wamba* (peasants) despite the debatable prioritising of national resources.

5.7 *Kukhwima*

We continue by looking at one of the mechanisms, *kukhwima* (fortification) recruited in the intense competitions for resources, which we suggested were crucial in *ufiti* construction.

5.7.1 Literature review

Breugel (2001: 247), in his 1970s research, records that, among the Chewa, traditional practitioners can offer protective medicines: *mtsiliko* to protect against sorcery and theft; an *mphinjiri* to 'ward off misfortune' or a *chithumwa* containing any number of protective or medicines designed to bring good luck. In personal protection, the *mtsiliko* may be administered in the form of scarification (*kutemera*). These are the same types of protective mechanisms recorded more colourfully earlier by Johnston (1897: 439 -

444) and Werner (1906: 82).

5.7.2 Current perspectives on kukhwima

In my interview with *sing'anga* Kumpolota, I sought to clarify whether *kukhwima* medicine really exists. Kumpolota confirmed

Yes there is *kukhwima* medicine. It means if someone wants to practice *masalamusi* (witchcraft) on you, it won't work. You are protected; but not protected against God's illnesses.³⁴²

In the general population the concept of *kukhwima* is very strong. It is not a concept that merely protects against *ufiti*, but illness and misfortune in general. In my reflexive introduction in Chapter One, I mentioned that one of the impetuses for this study was my brother's suggestion that one could not survive in Malawian politics without *kukhwima*.

To establish the extent of the power of the *kukhwima* concept among my students a number of questions about *kukhwima* were included.

5.7.3 Results of student surveys

Qualitatively, some of these students expressed clear beliefs in and knowledge of *kukhwima*. For example when asked: What, in your opinion, is *kukhwima* used for? The answers were:

Anon, Biology, Chancellor College (292): 'For protection. Some people are (made) bullet proof/sharp object proof'.

Anon, age 15, form 1 Zomba Catholic Secondary school (372): 'It makes a person ... think properly'

As to why there was a need for *kukhwima*:

Majidu, A. Zomba Secondary School, (363): '[the need for] *kukhwima*

³⁴² By God's illnesses Kumpolota means 'diseases of natural origin' (Cf. McKenzie, 1925: 273 and Van Breugel, 2001: 267).

[is] caused by fear of wizards’.

Asked about its efficacy, some were in no doubt:

Anon, Biology, Chancellor College (285): ‘Fortification works, I have seen it’.

And some specified where they saw *kukhwima*:

Mwale, M., (Std 8), Bwaila Primary School (473), ‘I saw [*kukhwima*] in Lilongwe’.

For further insights into how the students valued *kukhwima* I used a quantitative approach. The Question was: Do you think *kukhwima* protects from rheumatism, malaria, HIV/AIDS or *ufiti*? (Table 19). There were, looking at the table 19, very few students who thought that *ufiti* could cause HIV/AIDS. There was no discernible rural/urban, and indeed age or educational, dichotomy in the responses.

H. M. age 15, form 3, St Michael’s Girls secondary School (781): ‘I don’t believe in witchcraft although I hear people talk about it. I do not think HIV/AIDS and Malaria can be caused by witchcraft’.

From the quantitative figures above, most of the students clearly distinguish between those diseases or phenomena amenable to prevention by *kukhwima*, like *ufiti*, from those where there is some possibility, like rheumatism, to those where there is little (malaria) or very little possibility like HIV/AIDS.

The results, given in Table 19, show that the majority of students did not think that fortification protects against rheumatism, malaria or HIV/AIDS. However, over 40% of the St. Martin’s, Mangochi, Masongola, the First Year Philosophy, Third Year Philosophy, and 50% of the Second Year Theology students, thought that *Kukhwima* protects from *Ufiti*.

The highest number of those who thought *Kukhwima* could protect one from *Ufiti* were at Zomba Catholic Secondary School, and the highest number of those who thought *kukhwima* was not an effective protective against *ufiti* came from St. Mary’s, the girls’

secondary school two miles away suggesting a gender difference in the perception of *ufiti*, if taken in conjunction with the St. Michael’s figures.

(Table 19

Do you think *kukhwima* protects from rheumatism, malaria, HIV/AIDS or *ufiti*?

Question: Do you think <i>kukhwima</i> protects from rheumatism, malaria or HIV/AIDS and <i>ufiti</i> ?								
(All figures are percentages) ³⁴³								
	Rheumatism		Malaria		HIV/AIDS		<i>Ufiti</i>	
Site:	Yes	No	Yes	No	Yes	No	Yes	No
Primary:								
St. Martin’s n=43	09	44	12	51	05	53	42	19
Bwaila n=61	07	67	05	69	07	64	15	34
Secondary:								
Mangochi n=15	07	87	07	87	00	93	47	40
St Michael’s n=202	09	46	04	69	03	60	17	22
St. Mary’s n=21	10	57	00	86	00	81	38	43
Masongola n=18	11	61	06	72	00	78	44	28
Zomba Cath. n=16	11	67	00	94	00	89	78	00
University:								
1 st Year Ph. n=60	05	85	03	87	00	90	43	00
1 st Year Eng. n=98	11	67	03	76	02	77	35	37
2 nd Year Biol. N/A								
2 nd Year Th. n=12	25	58	08	83	00	100	50	25
3 rd Year Th. n=10	10	50	10	60	20	60	40	10

A locality/urbanity effect may also apply if the Bwaila figures are taken into account. The next task was to see how many would actually want to use fortification, (Table 20). Although the majority stated that they would not use fortification, there was a 00% to 19% scatter of affirmative responses (Table 20), with no rural/urban dichotomy. Here again the numbers of non-respondents – varying from 04% for the Second Year

³⁴³ Here only the Yes and No answers are given. Those who did not answer this particular question make up the difference between the total of those answering and 100%. As previously stated there were some non-item responses.

Theology students to 44% at St. Michael’s College – have to be noted.

(Table 20.

Question: Question: Would you think of using fortification yourself?				
Answer:	Yes	No	No answer	Total
Site:				
Primary:				
St. Martin’s n=43	14%	72%	14%	100%
Bwaila n=61	12%	49%	39%	100%
Secondary:				
Mangochi n=15	07%	64%	29%	100%
St Michael’s n=202	03%	53%	44%	100%
St. Mary’s n=21	10%	80%	10%	100%
Masongola n=18	15%	72%	13%	100%
Zomba Cath. n=16	05%	79%	16%	100%
University:				
1 st Year Ph. n=60	07%	79%	14%	100%
1 st Year Eng. n=98	03%	76%	21%	100%
2 nd Year Biol. N/A				
2 nd Year Th. n=12	19%	62%	19%	100%
3 rd Year Th. n=10	00%	80%	20%	100%

The responses in this table have to be contrasted with the higher awareness levels for *kukhwima* in Table 7. The implication was that although aware, some had no intention of using *kukhwima* and some did not like to commit themselves.

5.7.4 Conclusion

As for *ufiti*, the majority of students are not predisposed to use *kukhwima*. However, given that these surveys are of school students, the residual persistent concepts of protection versus prevention should be noted. In the absence of condoms in the Malawi

of 1985, when AIDS was first diagnosed, it is possible to see how some traditional practitioners could offer protection against sexually transmitted diseases. On a general level, this small proportion professing interest in using *kukhwima* could be said to reflect the school-going reality spectrum of the *ufiti* discourse.

5.8 Malaria

5.8.1 Literature review

Although, as *malungo*, malaria was known to traditional practitioners, Dr Charles Meller, was the first to note that indigenous people “have an almost perfect immunity to malaria” (King and King, 1992: 12). This ‘almost perfect immunity’ is reflective of the ‘value of life’ arguments; the residual proportion of non-immune indigenes still accounts for a large amount of morbidity and death in Malawi.³⁴⁴ The perceived immunity of the majority of indigenes therefore served to detract from medical provision in this area.

Some early western doctors like Livingstone showed respect for traditional medicine (ibid: 23), even though, given the limited use of indigenous languages for the diseases noted, no specific written references to *malungo* were made, either as the fever or disease. I could find no literature which assesses indigenous treatments of malaria in the colonial period.

In 1985, malaria was responsible for 10% of all (under five) children dying in hospital (King and King, 1992: 167), a vast improvement from the figures for 1927, where malaria contributed 52% of ‘infectious diseases at (sic) hospitals’ (ibid: 109).

Bisika (1996) found that in the Namasalima locality, people were familiar with symptoms often associated with malaria. What was interesting was the fact that they ‘use a variety of local terms and concepts to label and interpret’ these symptoms. He highlighted the confusion, familiar to western clinicians over the years, caused by the

³⁴⁴ Malaria is the second most common disease in Malawi after HIV/AIDS.

ubiquitous use of the word *malungo*, to mean fever, malaria or fever from other causes.

In terms of disease prevention:

13 percent of the households in Malawi owned one or more bed-nets. The average number of bed-nets per household was 1.6. Of the under-five children in Malawi, only 8 percent slept under a bed-net on the night prior to the survey. In urban areas, almost one in five (20 percent) under-five children slept under a bed-net the night prior to the survey compared to only 6 percent in rural areas (National Statistical Office, 2000b).

The bed-net possession mirrors the rural/urban and rich/poor figures.³⁴⁵

5.8.2 Current perspectives on malaria

My own findings, in 1995, 2000 and 2001, confirmed that malaria remains one of the most important diseases in Malawi. In six-month period between August 1994 and January 1995 at Lilongwe Central Hospital, malaria was, by far, at 12.2% (257 out of 2100 cases), the most common infection leading to hospital admission to the non-paying adult medical ward (Lwanda, 1995).

At Malindi, Zomba and Likoma rural people spoke of *malungo*, *nyamakazi* and *Edzi*, as being some of the commonest problems. The management of malaria varies between the elites who can afford blood testing and anti-malarials, and the majority, who treat the fever with *Panado* or *Aspro* (paracetamol or aspirin). In terms of causality, many now recognise that *udzudzu* (mosquitoes) plays a large part in the dissemination of malaria.

We have already alluded to the belief among some students and, incidentally, ordinary members of the public, that mosquitoes can spread HIV/AIDS. Even university students articulate this belief, in daily discourse, as witnessed during my focus group discussion with the theology students at Chancellor College.

³⁴⁵ 85% of Malawians live in the rural areas.

Despite the well-known association between malaria and mosquitoes, more often than not, their knowledge is not matched by the availability of anti-malarials. Thus

Kuno tikubvutika ndi malungo, mudzingotibweletsela mankhwawo (we are suffering from the ravages of malaria, just bring the anti-malarials please) (Manduwa, C, Personal communications, 1993 – 2000).

Having established, from observation and interviews, that malaria and its causes and treatments are now generally well recognised by the general population, I now turn to examine student responses to questions on malaria.

5.8.3 Results of student surveys

In the case of malaria, my respondents were quite knowledgeable about the causes, prevention and treatment of malaria. Asked about the causes and prevention of malaria, my respondents replied:

E. B. age 15, form 2, St Michael's Secondary School, (791): 'Malaria cannot be caused by witchcraft'.

C. B. age 15, Form 2, St. Michael's Girls Secondary school (881): 'No malaria cannot be caused by witchcraft'.

Mpalume, I, age 15, Form 3 Zomba Catholic Secondary School (352): 'use mosquito nets' [to prevent malaria].

Rodney, age 17, Form 3, Zomba Catholic Secondary School (356): 'we can use nets to prevent it'.

Banda, B., age 20, Second year Theology, Chancellor College (12): 'Use of antibiotics and repellents for malaria' SP and use of mosquito nets and hygiene to prevent malaria'.

However, there were some who were not sure:

K., age 13, form 2, St Michael's Girls Secondary School (773)
Witchcraft causing malaria? Maybe, but not really'

On the issue of whether traditional practitioners are in fact seen as being able to treat malaria, there was a difference of opinion:

P.N., age 16, form 2, St. Michael's Girls' Secondary School, (954):
'*Sing'angas* cannot treat malaria.

Chancy, age 17, form 3, Zomba Catholic Secondary School (357):
'Taking herbs from an African doctor'.
Ali, F, age 17, Zomba Catholic Secondary School, form 3 (350):
'Traditional herbs can prevent malaria'.

5.8.4.1 Conclusions

Malaria, in my student surveys, is generally and overwhelmingly recognised as a disease with a specific cause, 'plasmodium' and its mosquito transmitters, by my students. From the HIV/AIDS perspective, the fact that mosquitoes, which bite and suck blood, are vectors of malaria appears to cause some concern. It was felt that if blood transmits HIV, mosquitoes could transmit HIV. The implications of this for the poor and 'innocent' people who cannot afford mosquito nets and may thus contract HIV that way. Given that this is not a recognised mode of HIV transmission, this represents what we term 'diluting' effect of the phenomenological on the epistemological. HIV/AIDS awareness messages currently do not reflect the anxiety of those ill equipped to afford mosquito nets or repellents. In the rural areas burning dung and other vegetable matter is still resorted to as protection against mosquitoes. This resort to pre-colonial preventives and coping strategies for the second most problematic medical condition in Malawi confirms our argument that HIV/AIDS strategies need to be based on socio-economic realities. As with HIV/AIDS, there is thus a scientific, educational and socio-economic aspect to the malaria problem.

5.9 *Nyamakazi* (Rheumatism)

5.9.1 Literature review

In contrast to the situation in the UK, where rheumatological and muscular conditions form a significant discrete if diffuse group of illnesses, in Malawi, despite the ubiquity of *nyamakazi* as discourse,³⁴⁶ there were few admissions diagnosed with this group of condition. *Nyamakazi* (specific or non-specific back, joint or muscle pain) is probably

³⁴⁶ The commonest physical medical complaint among adults in Malawi is perhaps 'body pains', after *thupi kupweteka*, *kuwawa* or *nyamakazi*.

the commonest symptom complained of to doctors by adults in Malawi. This may be the only symptom and, from a medical perspective, result from hard work, poor bedding or other preventable causes like osteomalacia.³⁴⁷ My own survey of the adult wards, both paying and non-paying, showed only 30 (out of 2100) presenting in a six-month period (Lwanda, 1995). This is because, like *malungo*, *nyamakazi* is both a disease and a symptom.

5.9.2 Current perspectives on nyamakazi

Almost all my relatives, and those I met in the course of my fieldwork, who were aged over forty were likely to complain of *nyamakazi*. It was a common complaint volunteered on being asked: How are you? Most of my relatives were knowledgeable about management, herbal remedies from traditional practitioners or western medicine like the popularly known but often unavailable 'Indocid'.³⁴⁸

I noted that *nyamakazi* is still the illness most often associated with witchcraft. The symptomatology of intermittent, gnawing body pains, often worse in the morning (implying nocturnal interference), and the resultant suffering and misery of the patients, lends itself to *ufiti* discourse. Further, there are associations of *nyama* (flesh) with being bitten at night.

In my interviews I was not able to elucidate the significance of the female connotation in *nyama* (flesh/meat) and *-kazi* (female). This is an aspect that requires more work to elucidate the gender connotation. *Nyamakazi* is a good example of an existing syndrome to which indigenous beliefs, management systems and remedies have become attached. From the HIV/AIDS perspective, it gives some idea of what would happen, given time, to the HIV/AIDS syndrome if prevention and management continues to be dependent on traditional medical practitioners; a model of how people manage to cope with so much pain and suffering using traditional remedies. But unlike AIDS, *nyamakazi* does not normally kill.

³⁴⁷ A disease resulting from malnutrition and calcium deficiency.

³⁴⁸ The anti-inflammatory agent indomethacin. Ibuprofen (Brufen) is becoming more popular.

5.9.3 Results of student surveys

When asked about the causes, prevention and treatment of rheumatism, most of the students gave, not always accurate but, knowledgeable responses. They also echoed the issues of suffering and hard work in some of their responses. The question was: What causes *nyamakazi*?

M. G. St Michael's Girls Secondary School (931): [Rheumatism is caused by] old age, eating unbalanced diet'.

On prevention:

Makina, V, age 21, second year Theology, Chancellor College (1): living a good quality life e.g. good diet'

On treatment:

Munthali, P, age 20, Second year Theology (10): Taking painkillers.

Makina, V, age 21, second year Theology, Chancellor College (1): 'taking painkillers e.g. Indocid',

5.9.4 Conclusions

From my surveys, most of the students recognise the causes of *nyamakazi*. Perhaps because of its syndromic nature and long recognition, it was the disease most likely to be ascribed to *ufiti*. A study of the knowledge of causes of and management of *nyamakazi* shows that while students recognise it, their expected western remedies are not easily available to the rural and urban population. This model may be followed by HIV/AIDS if present prevention and management strategies are followed in the absence of adequate western resources.

5.10 HIV/AIDS

Having outlined the prevailing context we now turn to examine the results of the students' answers to HIV/AIDS questions.

5.10.1 Results of student surveys

In the case of HIV/AIDS there was a very clear understanding of HIV issues, even among primary school students, (Table 21).

The table 21 shows that students were very aware of the HIV cause or of the viral nature of the cause and its modes of sexual transmission.

Table 21

Question: Do you happen know what causes HIV/AIDS?						
(All horizontal columns total 100.00%)						
	HIV	Virus	Sex	Body fluids	Other	No answer
Site						
Primary:						
St. Martin's n=57	19%	04%	54%	02%	07%	14%
Bwaila n=33	46%	24%	27%	03%	00%	00%
Secondary:						
Mangochi n=42	55%	24%	10%	00%	02%	09%
St. Michael's n=59	34%	12%	32%	03%	00%	19%
St. Mary's n=29	48%	24 %	14%	00%	04%	10%
Masongola n=32	40%	06%	50%	00%	00%	03%
Zomba Cath. n=39	45%	31%	16%	00%	00%	08%
University:						
1 st Year Ph. n=14	64%	07%	07%	00%	00%	22%
1 st Year Eng. n33	70%	09%	03%	00%	00%	18%
2 nd Year Biol. n=23	96%	04%	00%	00%	00%	00%
2 nd Year Th. n=21	62%	19%	05%	05%	00%	09%
3 rd Year Th. n=10	50 %	00%	40%	00%	00%	10%

The next task (Table 22) was to see if the students were aware of how to prevent HIV/AIDS. The students themselves generated the categories given here.

Table 22 Question: How do you prevent HIV/AIDS?

Question: How do you prevent HIV/AIDS?							
(All figures represent percentages and horizontal columns total 100%)							
	Abstain	Avoid	Use	Avoid	Use	Safe	Not
		Casual	condoms	blood,	premarital	sex	answered/
		Sex		fluids,	checkups,		don't
				Razors,	& condoms		know
				abstain			
Primary:							
S/Mart. n=57	14	46	10	02	07	00	21
Bwaila n=33	70	15	00	03	06	00	06
Secondary:							
Mango. n=42	36	36	09	00	00	00	19
S/Mich. n=59	37	25	14	02	03	00	19
S/Mary n=29	45	27	07	14	00	00	07
Masong. n=32	28	56	00	03	03	03	06
Zomba n=39	63	21	00	00	05	05	06
University:							
1/Y Ph. n=14	71	00	07	00	00	00	22
1/Y Eng. n=33	49	00	00	03	00	12	36
2/Y Bio. n=23	48	00	18	04	17	09	04
2/Y Th. n=21	71	19	00	00	00	00	10
3/Y Th. n=10	50	20	20	00	00	00	10

It is clear that students are generally aware of the factors in HIV prevention. Most, at all sites, chose either abstention or avoiding casual sex as their main method of preventing HIV infection. At St. Martin’s the largest component, 46% chose ‘avoiding casual sex’. This was also seen at Masongola, Mangochi, and to a lesser extent, St. Michael’s. It could be inferred that fidelity in partnerships was seen as the next best to abstention.

In qualitative terms the responses, on how to prevent HIV/AIDS, were:

E. M. age 14, form 2, St Michael's Girls Secondary School (838): 'AIDS is a sexually transmitted disease'. .

Kalugwile, C. age 15, (35): I know AIDS is a very dangerous disease. Once you get HIV/AIDS, just know that you have dug your own grave, you are going to die'.

Mkandawire, age 27, Chancellor College, Year 3 Theology (88): 'Educating the communities more about the dangers of AIDS and its prevention'.

Z. J., form 1A, St Michael's Girls Secondary School (739): *Posagonana kapena kuvala condomu* (by abstaining or using condoms during sex).

Y. C. form 4A, St Michael's Girls Secondary school (721): 'By not having sexual intercourse before testing blood'.

Anon, Second year Theology, Chancellor College (19): abstaining from sexual intercourse'.

Despite the overwhelming knowledge of western concepts of HIV causality, there were a handful of dissenting opinions on the viral cause of HIV/AIDS. Some still saw a role for *ufiti*:

Mkandawire, H, age 17, Zomba Catholic Secondary School (377) 'Yes witchcraft can cause HIV/AIDS'.

There were, perhaps reflecting the difficulty of getting these, and the models of HIV prevention taught, only a small minority opting for condoms – ranging from 00% at Bwaila to 20% among the Senior Theology class. The low figures for safe sex, ranging from 00% to only 12% were significant; the models of HIV prevention are either absolutist (abstain, avoid casual sex) or permissive (use condoms). Few of the students, given the generally low 'avoid casual sex' responses, demonstrated pragmatic knowledge, in the sense that few recognised the need for concepts of safe sex, premarital or pre-relational check-ups.

In qualitative terms, the distinction between abstention and safe sex was only clearly articulated by a few students, an articulation more noticeable among the qualitative responses of the girls at St. Mary's and St Michael's Girls Secondary schools.

T.N. age 15, form 2, St Michael's Girls Secondary School (949): To prevent [AIDS] there is a need to abstain from sex, if you can't abstain, use a condom.

Kamtema, M. St Michael's Girls Secondary School (740): [Prevent AIDS] by having protected sex'.

M. D. Z. age 14 form 2, St Michael's Girls Secondary school (905): 'If you really can't [abstain], then use a condom'.
N. K., age 16, St Mary's Secondary School (81): 'Using condoms when having sex'
M. G., St Michael's Girls Secondary School. (735): 'By having protected sex'.

This section has shown that Malawian school-going students are aware of the scientific causes of HIV/AIDS but that there is a need to improve their practical knowledge of safe sex.

5.10.2 Conclusions

We have shown that students are aware of the scientific causes and prevention strategies of HIV/AIDS. However, this awareness contrasts with some of the personal and social denial and misconceptions current in the general population.

Of concern however was the aspirational nature of the known prevention strategies. The surveys among the female secondary school students did not suggest that they were being practically empowered to avoid HIV infection although they were being given factual knowledge about it.

Another area of concern was the fact that students are not told about safe sexual practices, preventive strategies are based largely on abstention.

5.11 Chapter Conclusion

Having noted some of the historical background, discussed in Chapter Two, this chapter has outlined the prevailing cultural attitudes and beliefs in Malawi as they impact on HIV/AIDS.

The chapter utilised triangulated research methods due to the need to illuminate the whole using parts thereof.

From a theoretical standpoint, an examination of the Malawian school system showed that the syllabus, revised partly because of HIV/AIDS takes cognisance of the social problems of Malawi. However, despite enabling an acquisition of theoretical

knowledge about issues like HIV/AIDS and malaria, it is unable to complete its intended developmentalist role because of its dependence on the village and its resources. Resource constraints, staff deficiencies and, ultimately, dependence on what we termed village culture leverage the balance towards traditionality.

But education succeeds in delivering a tiny proportion of children through the system; these lucky children become the elites who later control resources. Their almost miraculous transit through the system may imbue them with a justified sense of privilege, luck or superiority, qualities which are sometimes often later seen among resource allocators.³⁴⁹

We also noted that *ufiti* discourse is adopted and used by students, like the general population, in discursive, jocular or in a small, but unquantifiable minority, serious realistic mode. It was also argued that the use of this *ufiti* discourse is ‘helpful’ in explaining away and coping with the enormity of HIV/AIDS illnesses and deaths. This aspect may manifest as national or personal denial of the existence of AIDS illness in a particular situation.

It was also noted that *ufiti* discourse is utilised by governance in modes that control order and legitimise the denial of resources to ordinary people.

Another use of *ufiti* discourse was in achieving subtle public socialising. We noted its use in crime prevention. This concept of a positive *ufiti* that protected goods resonated and was allied to *kukhwima*. From the perspective of HIV/AIDS, we argued that these mechanisms and dynamics, while permitting national order and ‘health’ have a negative

³⁴⁹ This concept of luck and privilege mirrors the colonial access to resources by whites using colour as a descriptor; in the postcolony *achikulire* have access to more resources than *anthu wamba* using the class descriptor. This access differential, partly a hangover from the colonial era, is seen in the public service, where public officials, by virtue of their privileged office, exact servitude from their clients. MPs, senior civil servants, cabinet ministers, medical personnel, senior (government, NGO and private enterprise) clerks, and others, may not behave as public or customer’s servants but as their resource masters. This relationship between elites and peasants contributes to a stronger intra-elite cohesion than intra-elite contests, a cohesion that can be summed up as *bwana ndi bwana basi* (the master is the master, period). Such discourse, and other constructs, reifies the elite/peasant boundary in Malawi to a marked degree. The *achikulire*, like the colonial officials before them, use this construct both to evade the *ufiti* connotations of excessive wealth in the middle of widespread poverty and to maintain a degree of order in the middle of poverty.

and dilutory effect on western models of health promotion. Hence some traditional practitioners can claim to be able to protect against STDs.

Thus the almost perfect knowledge the students acquire about the causes of HIV/AIDS becomes a theoretical tool, which students are subsequently unable to utilise primarily because of the lack of resources but also because of the coping strategies, which have arisen to compensate for this lack of resources.

It was subsequently shown, using literature review and my own data how these cultural norms interact with the knowledge obtained by students at primary, secondary and tertiary school levels.

From both qualitative and quantitative surveys it was shown that students are well aware of 'scientific' diseases like malaria and HIV/AIDS. We have also noted that they are well aware of syndromic concepts like *nyamakazi*. And we have noted that a significant section is aware of the reflectors of traditional causality, *ufiti* and *kukhwima*, although only a small minority intended to use *kukhwima*. Specifically, we have noted that *ufiti* is regarded as a negative malign and selfish force. From a purely western medical perspective, the Malawian secondary school students were highly aware of the scientific issues of malaria and HIV.

But it was argued that, because of the unresolved historical, educational and socio-economic context of these cultural norms, dualities, hybridities and ambiguities arise.³⁵⁰ These subvert and partly disable western HIV/AIDS health prevention messages.

This subversion, we argued arose from a number of mechanisms.

First. We noted the inherent appropriateness of traditional culture, given the socio-economic context.

³⁵⁰ Hybridities here are those cultural orientations educated by both western and traditional origins. Hybridities as defined here recognise the distinctness of each culture and an awareness of the contradictions is usually maintained. Ambiguities on the other hand appropriate elements of each tradition regardless of the contradictions.

Second. We noted that a number of social constructs are erected and maintained at local, territorial and national level which compensate for resource deficiencies and enable the continuation of social and medical order. These constructs balance the demands of gender, class, religion and political power brokers. Some of these constructs depend on state powers, religion (indigenous as well as Christianity and Islam), patronage and what we termed *ufiti* discourse, for example. We noted the explicit use of *ufiti* discourse and constructs by the state.

In the next chapter we show how this cultural background interacts with the socio-economic context to produce the socialisation that educates the subsequent interactions and behaviour of students and other young people with western and traditional medicine in the context of HIV/AIDS.

CHAPTER SIX

Localised cultural attitudes and beliefs: a model of socialisation

6.1.1 *Chapter Methodology*

This Chapter utilises archival material and data from my fieldwork. Beginning with data from my fieldwork and critical reviews of previous study material it suggests a model of how cultural attitudes and beliefs, towards health in general and HIV/AIDS in particular, are developed and maintained. This is achieved by the interplay between my original ideas and previous theoretical frameworks of socialisation.

The chapter seeks to demonstrate, given the findings in Chapter Five, that the suggested forms of socialisation, as they relate to HIV/AIDS, are dependent on, if not predicated by, the socio-economic context.

6.1.2 Localised cultural attitudes and beliefs: a model of socialisation

Having examined the history of pre-colonial medicine in Chapter Two, the role of colonial and postcolonial governance in Chapter Three, the history of HIV/AIDS in Malawi in Chapter Four, and the prevailing cultural beliefs and attitudes relevant to medicine in general and among school students in particular, we now turn to an examination of why these cultural attitudes and beliefs, as they relate to HIV/AIDS, are maintained, despite the forces of Christianity, Islam, Western education, the increasingly globalised media and other external influences.

It is being argued here that the cultural dynamic is being maintained because of a number of reasons:

- The socio-economic context

- The large unmet 'western' medical needs
- The gap between aspiration and reality in relation to western medicine
- The vibrancy of indigenous traditions
- The quality and quantity of western education available
- The nature and quality of health education available
- The imperative to maintain general public order for the benefit of elite-based governance.

These factors, it is asserted, are the substrata upon which socialisation, in relation to HIV/AIDS is based. This socialisation, it is argued is achieved largely through oral, rather than written modes. Oral modes, both spoken and musical, are amenable to dilution.

It is argued that the net effect of the socialising process is to produce two main distinct cultural traditions, the western and the traditional, with hybridity and ambiguity in the middle. It is argued that most of those who benefit from western schooling or contact with the western medical traditions, as the student questionnaires show, prefer western medicine but may revert to, or be forced to depend on traditional medicine given the unavailability of the former.

6.2 The Social, economic, cultural and educational imperatives

6.2.1 Poverty and land shortage

Balala! Balala! Mabvuto m'mbuyumo, tiyeni tithawe!

(Scatter! Scatter! Trouble follows behind, let us all run away!)

This section identifies the factors that favour localised cultural attitudes being developed and maintained. It has been argued that cultural practices are usually appropriate to environmental settings and resources and other factors (Cf. Kuper, 1999: 245 - 247). Here, the first task is to demonstrate that despite colonialism and post-coloniality, the majority of rural Malawians still have lives largely located outside the

formal westernised sector, lifestyles which favour more traditional cultural norms.

Malawi is still largely an agricultural country of extreme rural poverty (Carr, 1994). The main reason for this poverty was advanced in chapter two: land shortage. To this can be added: the unfavourable climate, and the lack of access to cash crop growing (Carr, 1994: 32 - 38). Further, as Table 23 below shows, the population of Malawi has increased ten-fold since 1901, but without a corresponding increase in land.

TABLE 23: TOTAL POPULATION: 1901-1998 CENSUSES

YEAR OF CENSUS	TOTAL POPULATION	AVERAGE ANNUAL INTERCENSAL GROWTH RATE (%)
1901	737,153	-
1911	970,430	2.8
1921	1,201,983	2.2
1926	1,263,291	1.5
1931	1,573,454	4.4
1945	2,049,914	2.2
1966	4,039,583	3.3
1977	5,547,460	2.9
1987	7,988,507	3.7
1998	9,933,868	2.0

(National Statistical Office, 2000b)

It has been documented that during almost each decade, the level of poverty in Malawi has been increasing (Chinsinga, 2000: 2). In 1938 (MNA S1/138I/36: 15) the reasons for the Malawian population’s generally poor nutrition were given as: poverty and disease; inadequate transport facilities for the distribution, and inadequate and lack of facilities for storage of food; and a lack of imported foodstuffs at a time of seasonal shortage. Twenty-five years later, just before independence, it was observed

The needs of the youth must be seen in the context of the economic and social development of the whole country, not as something special or apart from this development. Nyasaland is and will probably remain primarily an agricultural nation. A major problem is ... how to increase agricultural production. The country is moving from subsistence to a cash economy. We have little information on how this process is proceeding... (Benedict, 1963: 19 – 20).

This transition from a subsistence to a cash economy has not been significantly accomplished. Thirty six years later, in 1999, the situation was, if not identical, worse:

Malawi is one of the poorest countries. It heavily relies on agriculture for food and income. Its economic structure is therefore fragile and open to the vagaries of weather and terms of trade swings. Its public finance is dependent on the benevolence of donors and few and over-used tax handles. The demands on public finance are so overwhelming that the resources are spread too thinly to have any meaningful impact. Poverty, which is so pervasive as to affect as many as sixty-percent of the people, has relentlessly continued to affect new victims despite positive per capita growth rates over the years (Tsoka, 1999: 1).³⁵¹

Effectively then, in real terms, while the population has increased, there has been little compensatory macro-economic and the micro-enterprise activity to compensate (Pryor, 1991; Mhone et al., 1992; World Bank, 1995; Chinsinga, 2000). And land shortages have intensified (Chinsinga, 2000: 12); rural subsistence farmers now have less land than in 1901.³⁵² Of the 66% of the Malawi population that is economically active, 78 percent are *alimi* (subsistence farmers); they each have less land than in the colonial era.³⁵³

In terms of employment, the 2000 census showed that of 'the 4.5 million persons aged 10 years or over about 3.7 million (83 percent) were in the Agriculture, Animal

³⁵¹ It has to be noted therefore that these 'thinly spread' public resources were known about at independence. If this factor is taken into consideration, it will be seen that there has been a further dilution of public resources available to ordinary people, as the elite has grown in size.

³⁵² In fact subsistence land has been eroded further by the growth in the estate sector between 1964 and 1990 (Cf. Pryor, 1991). After the onset of multi-party rule some newly empowered *achikulire*, including Brown Mpinganjira, allegedly established estates by 'grabbing land'. See 'UDF leaders grab land in Mulanje' *Malawi News Online*, 22, 21/10/97 at

http://www.sas.upenn.edu/African_Studies/Newsletter/mno22.html.

³⁵³ Existing on incomes of between \$40 and \$55 (1995 value) in 1995 (World Bank, 1995: 24 – 25).

Husbandry or Forestry sectors while only around 7,000 (0.2 percent and predominantly male) were in Administrative and Managerial sectors' (NSO, 2000), confirming the largely rural pattern. The over-dependence on subsistence farming is made worse by the environmental degradation caused by deforestation resulting from cutting firewood for fuel.

From a socio-cultural perspective, the majority (69%) of the 2.3 million households in Malawi were male headed (ibid, 2000). The worst poverty was seen among the 31% of households headed by females (Kaunda, 1990: 413 – 430).

In terms of infrastructure, in 2000, 'of the 9.9 million household-based population, 6.5 million (66 percent) lived in dwelling units that had thatched roofs with mud walls, or walls made of mud and wattle; that is, traditional structures' (NSO, 2000). Only '1.6 million (16 percent)' lived in structures that could be classified as permanent structures (ibid). The majority of Malawians (94 percent) used firewood, only 2 percent used electricity for energy and cooking, and 90 percent used paraffin while only 5 percent used electricity for lighting (NSO, 2000).

From the socio-medical perspective, in 2000, only about 2.6 million or around 27 percent had access to boreholes as their main source of drinking water, while 2.5 million or 25 percent drank water from unprotected wells. Only 21 percent used either piped water or communal standpipes as their main sources of drinking water. As for sanitation 7.2 million or 73 percent of the total population have access to traditional pit latrines, while 2.2 million or 22 percent had no access to any toilet facilities at all (ibid, 2000).

In terms of communications, about 4.9 million or roughly half of the total population had access to at 'least one radio' and 4.0 million or 41 percent had access to at least one bicycle' (NSO, 2000).

Thus, ontologically, physical urbanity and infrastructural modernity, from a health point of view, effectively only affect, using those figures, about 05 - 06% to, at best 16% of the population.

In medical terms, this socio-economic reality is demonstrated, for example, by the fact that only 35% of all children with fever (*malungo*) were treated at a 'modern health (i.e. western medical) facility' in 1996 (MKAPHS, 1996), and 60% (MDHS, 1996) and 52% (National Statistical Office, 2000b) of birth deliveries in rural areas were performed by traditional practitioners. Taken together with data presented in earlier chapters this shows the dependence on traditional medicine because of the limited western medical services.

While some observers see a traditional culture struggling to cope with modernity, this study would argue from a different perspective. It is argued that, given the poverty dynamic and its culturally ruralising and traditionalising effect,³⁵⁴ it is a theoretical and, often, tangential modernity that is struggling to cope. The resultant - for practical reasons and not symbolism - dualising, hybridising and ambiguity creating dynamic leverages communities, from a health sector perspective, towards indigenous practices and behaviour. As psychiatrists hold, every sane person wants to get better and will use all reasonable means to achieve that goal. In this regard Otoo's (MOH 1972: 92) observation, made in the context of comparing western to traditional medicine, is apposite:

Most rural communities are well organised and there are mores and patterns of behaviour associated with illness within the communities. ...[the system has the advantage of] cheapness. ... Furthermore it reaches everybody. ... The guardians of the culture and norms of behaviour and the conscience of the communities are the elders, and every citizen is a policeman to see that those who infringe the unwritten code of behaviour and mores are brought before the guardians.

Thus people may resort to or favour the rural cultural norms and socialisation because they are appropriate to the socio-economic ontology. But this appropriateness is contingent on communal cooperation. This is the social context in which HIV/AIDS arrived. It is a social context exploited by the state as an alibi for inadequate resources and to preserve elite social and economic advantages at the expense of the majority poor. But to preserve a harmonious dynamic between the poor and the rich a dialogue

³⁵⁴ To ensure communal support and welfare.

and a socialisation based on rural discourses and norms are utilised.

6.2.2 Unmet need

The vast chasm between need and services in current HIV/AIDS and STD prevention strategies has already been noted for example in the Family Planning sector (Palamuleni, 1998). And Chimbwete (2001), in his survey of young people's sexual health, confirmed this unmet need, finding that, although most women were sexually active and married by 18, 'the use of modern methods of contraception is low at all ages'. Although most family planning services may be free, the access points for these are mostly urban or peri-urban. Even if access were possible for all, resources could not match these needs, particularly in the rural and peri-urban areas of Malawi. The MOH (1999: 5) itself admits, of its infrastructure:

The results of both studies ...provided the hard evidence for what everyone had come to suspect. The health facilities stock is deteriorated and unable to meet the current demands placed upon it.

The MOH has some successful sustainable interventions, particularly its childhood vaccination programme. Childhood vaccine uptakes of up to 55% were achieved in 1996 (MKAPHS, 1996).³⁵⁵ However, some of these figures are disputed, with Chilowa (26 –27) showing a downward trend in the Expanded Programme on Immunisation since 1992.

In coping with these unmet needs rural communities recognise the deficient and intermittent nature of what can be termed interventionist modernity. This recognition was noted by Chiwoza-Bandawe (2000) during his study on the psychology of Bilharzia treatment. He demonstrated that rural school children, and their parents, use a number of devices in deciding which external donor funded community self-help initiatives to support. These projects were assessed by the community for their benefits to individuals and the community. Chiwoza found that projects that tended to reward individuals were more likely to lose community support; in effect that sustainability

³⁵⁵ Vaccination, in its varioalation guise, was traditionally practiced in Malawi during Smallpox outbreaks.

may depend on communality.

Western paradigms are usually seen as promoting personal choice rather than communality of choice. This resonates with the perception of those who have excess resources while others go hungry as either *afiti* or protected by *kukhwima*. Where sustainability is only a possibility, then communities rightly tend to prefer the stable status quo. Socialisation is therefore leveraged towards communal traditionality.

6.2.3 Gap between aspiration and intended reality

We saw, in Chapter Four, that the fulfilment of the NASF was contingent on donor funding. There is therefore, at present, a seemingly unbridgeable gap between the aspiration, that HIV/AIDS can be tackled, and the intended reality.

The theoretical HIV/AIDS prevention knowledge of my respondents cannot at present be fully translated into full service provision. Thus, even some of the less extreme solutions of one of my respondents must remain largely theoretical:

Bhika, D, age 18, form 3b, Zomba Secondary School (361): I think it is a must that any person in the country should be tested [for HIV]. The HIV positive people should be well known and [we] should not let them have sex with HIV negative people until all affected people die. The remaining people should be negative.

As currently formulated, the NASF may or may not recognise that secondary school students in Malawi may be as sexually active as their counterparts in other countries. The higher age of secondary school students in Malawi would make this more, rather than less, likely. Secondary school students in Malawi vary from 14 to 20 years of age, compared to 12 – 17 in Scotland for example.

Yet we noted the dependency and emphasis on aspirational abstention, avoidance of casual sex, and using (hard to obtain) condoms, with little emphasis on safe sexual practices. This socialises the young to view the often-problematic avoidance as the only real option.

This taboo model was reflected by one of my respondents comment:

Anon, Second year Theology, Chancellor College (14): 'Is it true that there are some drugs which can cure AIDS, but people do not want to bring them out, because they fear that people will just be doing whatever they want e.g. sexual intercourse?'

Given that this gap between aspiration and reality is, in practical human terms, too large to bridge for some, the advice to abstain may be seen as a 'taboo' to be broken by some adolescents.

Similarly, the use, experience and internalisation of traditional medicine by school going Malawians, in part, reflect this unmet need for western medical services. Thus, by the time they reach senior primary school, many are already positively, for reasons of practicality and need, engaged with and socialised towards traditional medicine. This knowledge is carried over into schools and in interaction with peers produces further modifications to these hybridities, dualities and ambiguities.

Until western medicine, and its associated socio-economic culture or traditions can offer adequate alternatives, the traditional framework and its rules - itself akin to the health and welfare systems of Europe and their rules and regulations - and associated beliefs guarded by culture brokers, will continue to try to fill this gap.

Seen in this light, the problematic of basing HIV/AIDS preventions and treatments largely on strategies based on aspirational western-based socio-economic models becomes more pronounced and only promotes the very anti-developmental discourse and socialisation it intends to abolish.

6.2.4 Strong Traditions

We noted, in Chapter Five, that the generic terms *mwambo wathu* (our tradition) or *mwambo* (tradition), in conjunction with other terms and signifiers, like *ulemu* (respect), encompass a group of formative norms enforced via a series of rules and rituals. Political, culture, gender and other power brokers uphold these rules, which are

grounded in the localised socio-economic, religious, moral and political beliefs and systems. Sembereka (1996: 24), writing about the *gule wamkulu* society of Mvumba, Mangochi, noted of the *nyau* religious complex group affairs and performances (*Gule wamkulu*),

Group affairs of this nature are fertile grounds for manipulating the people's consensus on the maintenance of traditional activities and should be seen as opportunities provided by ancestral spirits in providing all members present to participate either as mere observers or observer/participants. Performances during rituals and ceremonies create situations whereby members of the larger community appreciate the socio-religious role played by *gule wamkulu* in the society. Furthermore, the performances although rooted in ritual, are strong binding factors between members and non-members of *Gule wamkulu* under the aegis of the society, in so doing ensuring cultural continuity.

This need for rituals that perpetuate the social security systems also applies to the other cultural practices, such as *chinamwali*, *jando*, *nsondo* and *chileza* (last phase of the funeral rites) that provide frameworks for communal behaviour. These vibrant traditions, as we saw, may be problematic in HIV/AIDS prevention, the observance of some cultural practices negating efforts to improve women's health (Cf. MOH: *Making motherhood safe*, 1995). They socialise women in ways that impede HIV/AIDS preventive measures.

As noted in Chapter Five, with its high level of education and longstanding Christian penetration, Likoma is the last place one would have expected to find high levels of traditional practitioner use. But as Kafumba-Utonga (1981: 57 – 63), in critiquing the Anglican Bishop Hines prophecy about western medicine, noted

Western medicine's unique competence was accepted and appreciated, but not at the expense of traditionally derived therapies... Each of the therapy synthesis is concerned in a social consensus... an agreement of ideas... [Bishop] Hines statement, quoted earlier on, only shows how optimistic he was about western medicine's triumph over the traditional practitioners. He thought with civilisation, increased literacy and technological, economic and social change, people's attitudes would change towards western medicine orientation. But [...] civilisation has

actually increased the practice of witchcraft.³⁵⁶

Kafumba-Utonga himself here misses the point by appearing to accept that ‘civilisation, increased literacy, and technological, economic and social change’ had occurred. While Likoma undoubtedly has high literacy rates and high educational attainments, it does not have the degree of urbanity or modernity associated with technological or ‘economic’ change. In fact, as we saw in Chapter Five, many school leavers have to leave Likoma for the mainland in search of jobs. This population drift causes social problems, which in the absence of formal social security systems, are solved by traditional extended family support and socialisation.

This resonates with the thrust of the argument in this thesis that education, in the sense of western ideas and aspirations, without the socio-economic means to achieve or make practical those aspirations, cannot achieve a behavioural shift.

In the case of Likoma, the socio-economic means does not just mean a hospital; it means a regular supply of medicines, condoms, and, more importantly local jobs that would ensure less migration and gender imbalance. When all these other factors are missing, traditional practitioners offer a ‘deeper understanding in the context of culture’ and more time for their patients (Chalanda, 1987: 97). They may also communicate better than harassed clinical officers and may offer more pleasant clinical surroundings; in other words, they offer sustained social support and practical answers using available resources from within the island or from the mainland.

6.2.5 Limited formal educational resources.

6.2.5.1 General education

In chapter two we noted the limited educational opportunities for Africans during colonialism. Even in the postcolony, education remains limited and village based, with only 1 in 100 primary school graduates proceeding to secondary school (World Bank,

³⁵⁶ Likoma Cathedral was built on a *Chipyela* (a place where witches were burnt) (MNA PAM 434).

1995: 13). Nationally, educational services, resources and accessibility remain inadequate. Even local elite schools are, in many cases, more dependent on village resources than national ones, as the two examples show.

Case Study: St. Martin's Primary School. This Anglican Primary School, based at Malindi is one of the best in Mangochi, by virtue of its site in a major missionary centre and hence the help it gets from national, missionary, local and donor agencies. Yet during my visit I found that one of the classrooms had a leaking roof. Mr Nasoro, the Headmaster informed me that the school resources were so deficient that the school had only one atlas for the 500 pupils. There were no desks or chairs in the three rooms used for my questionnaires. Pupils had to share pencils or ball pens. Malindi School serves a twenty square mile area.

Case study: Likoma.³⁵⁷ Likoma Island is a stony outcrop on Lake Malawi of 16 square miles. That education is still 'village based' and that there was a dichotomy between educational aspirations and socio-economic reality was demonstrated by the Likoma School's open day, the local component of the national 'Education Day'. Activities featured traditional dances, *chiwoda*, and *malipenga*, the two most popular Likoma island cultural dances.³⁵⁸ There were plays emphasizing the importance of education in obtaining 'better employment'. HIV/AIDS awareness issues were also tackled using the 'condom/abstinence paradigm'. Likoma Primary and Secondary School buildings are better maintained than those at Malindi Primary School, and on a par with those at St. Michael's Girls Secondary School at Malindi. However, the Anglican mission at Likoma, with its associated hospital, and primary and secondary schools, represent the only cash employer of significance. The nearest industrial or civil

³⁵⁷ The 2000 Census shows that Likoma Island with a population of 8,074 (1998) exhibits the lowest sex ratio at 85.9 (85.9 men for every 100 women). The population in 1977 was 7862. The effects of HIV/AIDS and other causes of death on the population of Likoma is shown by the fact that the Census 'shows that the highest proportions of children with dead parents lived in Likoma District where 16 percent of the persons aged 20 years or less reported that one of their parents or both parents were dead at the time of the census'. Likoma school children will need to migrate if they are to rise above the Likoma 'village level' to better themselves. The prospect of employment on Likoma is minimal, the only significant employers, apart from its fishery, are the mission, the hospital and the school. Migration in turn means compounding the social strains caused by the sex ratio. These strains are relevant to public health, particularly where healthy leisure activities are limited. In 1966 Kafumba-Utonga records that 531 males and 1122 females had no education, 1742 males and 1999 females had primary education, 61 males and 39 females had secondary education and 2 males and 1 female had university education. These, for 1966, showed a very high level of western education.

³⁵⁸ Video recordings in my archives.

service employment opportunities are to be found on the mainland at Nkhata Bay, twenty minutes flight away. Likoma schools were also short of essential history, biology and mathematics textbooks.

These two local schools with national, local and international networks of help are used to demonstrate how ill equipped even the better local schools in Malawi are. These poor facilities are compounded by deaths, many from HIV/AIDS (NASF, 2000), of critical teachers and lecturers. This loss of teachers leverages the postulated battle between modernity and tradition in tradition's favour by reducing the chances of a critical dialogue between the two traditions. Those teachers, with the necessary experience, knowledge and skills to impart the necessary critical skills to enable students to tease out the harmful from the beneficial in traditional medicine are becoming less in number rather than more. In 2001, Malawi is estimated to have lost 7,500 out of its 60,000 strong teacher workforce.³⁵⁹

If education facilitates the movement from more 'traditional' to more 'westernised' lifestyles then this loss confirms that it is 'western modernity' which is failing to cope in Malawi.

In the short-term a revised look as to how the western aspirations of students and their village-based ontology can benefit from the educational system may be of advantage. The primary educational system should facilitate bright pupils' progress to the limited secondary schools, while the rest benefit from an acquisition of theoretical, social, agricultural, business, health, technological and other coping skills. They would also need to be helped to develop critical appraisal skills by the end of primary education to equip them to engage with and cope with the cultural duality and its ambiguities in the context of the current socio-economic situation.

Only thus mentally equipped, materially empowered and critically, but usefully engaged, could they hope to challenge some of the more harmful traditional concepts of social behaviour relevant to HIV/AIDS.

³⁵⁹ See <http://www.allafrica.com/stories/200201310277.html>.

6.2.5.2 Health education

We have already noted that, even as late as 1946, health education was a limited concept in Malawi, with 'no organisations in Nyasaland whose whole efforts are directed to health education' (MNA Miscellaneous file No. 505). And family planning services were only tentatively introduced in Malawi in the early 1960s (MNFPS 1994: 1). For political reasons, as we noted in Chapter Four, the approach, philosophy and rationale of the programme were not clearly articulated. At the First Inter-ministerial and inter-sectoral Workshop for the development of policies and strategies in health education in Malawi (1983), the definition of Health Education that was used was

any combination of information and education activities leading to a situation where people want to be healthy, know how to attain health, and do what they can individually and collectively to maintain health and seek help when needed.

This definition, intended to promote western health education, is in the postcolonial Malawian context paradoxically permissive of the acquisition of knowledge from other sources and other forms of health socialisation. And yet, in spite of the inadequacy of western services, a major factor in the HIV/AIDS epidemic, little has been done so far to exploit the possibilities of using traditional systems to promote health. Although the definition above clearly recognises that the individual is susceptible to the broader socio-economic constraints most Malawi health promotion models are predicated on concepts more appropriate to more urbanised or westernised societies.

At the beginning of the HIV epidemic the MOH correctly advised that, as far as HIV was concerned, the only solution was prevention (*Moyo*, 1986). For most of the 1980s and 1990s the health promotional messages were largely aspirational at a time when western medical practices, especially on rural people were contributing to HIV/AIDS spread.³⁶⁰ This aspirational element contributed to the perception that the preventive

³⁶⁰ Many health workers such as clinical officers, nurses and medical assistants performed deliveries and other procedures without gloves. Due to shortages the sterilising of re-usable needles and syringes was less than ideal. (Personal communications, and personal observations, 1993 - 1995).

measures were punitive, at a time when the ethos of governance was itself punitive of dissent. A natural reaction of some was to look for traditional cures for the foreign punitive disease. Echoes of this perceived punitive nature of an imposed disease were noted in the ‘American Invention to Deprive Sex’ (AIDS) discourse of the 1980s and persist in the musical discourse of the present, for example *Tikutha* (we are perishing).

It is, in retrospect, easy to understand why a combination of constrained socio-economic circumstances, a disease with no cure, a punitive environment and prevention regime could evoke the same feelings, as in the pre-colonial era of *mtundu utha ngati sitithawa* (the clan will perish if we do not move) noted in Chapter Two as *Balala! Balala! Mabvuto m'mbuyomo tiyeni tithawe!* (Scatter! scatter! Trouble follows behind, let us run away).

Thus the original HIV/AIDS health education messages were flawed, not in their scientific accuracy, but in their contextual applicability. Further, in health promotion terms, the concept of blood passing on infection, given the *mdulo*, *tsempo* and *kanyela* concepts, was already known from the traditional and transgressive perspective based on the concept of passing disease via blood. However, western health workers did not exploit this epistemological bridge. Lacking an explication of the viral nature of the HIV, as in *kachirombo* terms (see Chapter Four), but aware of *kanyela*, it is little wonder that both sides of the dialogue felt each side was confusing the same thing.

Current western health promotional models in Malawi are partly, if significantly, handicapped by their large aspirational quotient. Even when a cultural problem is identified, the solutions are still aspirational. Tembo et al's (1994) solution of ‘re-socialisation programmes for adults, elders, sex educators (*anankungwi*) and village headmen in rural villages’, as well as the ordinary health education element of the NASF, are bound to prove difficult to implement using western concepts on a socio-economic base more appropriate to prevailing norms.

These western concepts of ‘re-socialisation’ as we suggest later, can only be successful if the socio-economic environment changes or if the ‘re-socialisation’ takes into account the socio-economic realities.

6.2.6 The maintenance of order in a largely informal socio-economic context.

Policing elites, repressing the masses (Lwanda, 1992)³⁶¹

It was noted in Chapter Two how certain socio-cultural concepts were essential in maintaining order in pre-colonial times, leading to taboos and rituals, some of which had persisted in localities in the postcolony. We suggested that these are important in the maintenance of order, social cohesion and social security in rural and peri-urban areas. Clearly, then, were it possible, the strict observance of western concepts of health promotion would have consequences for a number of crucial aspects of Malawian culture which represents these localised cultural frameworks. For example, if the observance of *chokolo*, *nsondo*, *jando*, *chinamwali*, *nyau* and other rites were to suddenly cease, the framework of rural socio-medical-cultural order would undergo a profound change, with the loss of significant power by the male and female power brokers who set the parameters of communal health.

Yet we note that the NASF seeks to empower traditional authority, and indirectly, these cultural power brokers, to reverse the erosion of some of the hierarchical power experienced following the end of the Banda era (Cf. Phiri, 2000). There is a clear dynamic contradiction here. Given the poverty of central government resources in rural areas, including the police, the maintenance of socio-economic and socio-political order in rural areas is usually via traditional authority and constructs.³⁶² The uncritical empowerment of these traditional authority figures could easily prove to be counterproductive in the HIV/AIDS debate.

In most parts of Malawi, unless interfered with from central government or by the

³⁶¹ From an early UDF samizdat, 1992.

³⁶² During the one-party era, MCP officials sometimes sought to usurp these functions, culminating in the village party chairmen competing with chiefs for village authority. The post-Banda United Democratic Front has attempted to emulate this by appointing regional and district 'governors'. However, the chiefs now have significantly increased powers, which are nevertheless undermined by corrupt party officials (Cf. Chirwa and Kanyongolo).

ruling party, these traditional constructs remain robust. The NASF empowering of traditional authority may, from the HIV/AIDS perspective, involve indirectly strengthening the very perverse cultural activities and practices requiring 're-socialisation'.

There is however another dimension. Perverse or not, some of these cultural constructs and practices, as we have noted, directly or through recruitment into *ufiti* discourse, legitimise traditional authority and, in the postcolony, national authority.

We also noted that postcolonial government has used traditional social constructs and *ufiti* discourse partly as an alibi in the absence of adequate western resources.

Increasing the power of traditional authority in an uncritical manner is not necessarily therefore in the interests HIV/AIDS prevention.

Another dynamic is the fact that central government constantly seeks to increase its own powers, at the expense of local and traditional authority (Chirwa and Kanyongolo, 2000). As donor resources dwindle and the health expectations of the population rise, the resource strapped central governance attempts to be both developmentalist and traditionalist at the same time.³⁶³ By sometimes resorting to the socialising use of *ufiti* discourse and to tools like *Nkhani za m'maboma* (District News) a balance between respecting *mwambo* (culture) and order maintenance in adverse circumstances is facilitated. And by offering an aspirational developmentalist discourse in the NASF, central governance is thus seen to achieve both functions. But these conflicting strategies serve to dilute and subvert western health promotion messages of HIV/AIDS prevention.

³⁶³ As the negotiations with the donors and the IMF for aid took a turn for the worse in January 2002, it was noticeable how senior politicians began to appeal to 'national pride', 'sovereignty' and other 'traditional' Malawi attributes in public meetings. The 2001 – 2002 Malawi famine also illustrates another dimension in donor/recipient dynamic. While the Malawi Government initially cited 'sovereignty', as the famine worsened and the Malawi Government got most of the blame, it shifted its stance and alleged that the IMF had told it to sell the maize reserves. But the IMF said that it had advised the selling of only part of the maize reserve. The government could thus maintain its ambiguous 'traditional' sovereign and developmentalist IMF orthodoxy following nation.

6.2.7 Some constructive traditional cultural constructs

We have already examined the tools used by central governance in communal or rather national socialisation. These involve the government dominated national broadcasting station, the MBC.³⁶⁴ The first tool used on the radio is *Mauthenga achisoni* (death notices). The MBC must be one of the few national broadcasting stations to feature a half hour programme of death notices.³⁶⁵ This programme may run adjacent to *Nkhani za m'maboma*, and given the high numbers of deaths announced ensures that everyone is aware of these occurrences. While it fits in with the cultural practices of according the dead high respect, in line with *umunthu* (humanity) concepts discussed below, it has other effects.

Mauthenga achisoni, which was started, apparently, by virtue of 'public demand' can last for half an hour each night. It is traumatic to hear of up to fifty or more dead people each day. Radios are very popular with school students, and given the virtual monopoly of the MBC students listen to these messages.³⁶⁶ If anything were to dent high-risk taking at an aspirational level, this programme would be it. *Mauthenga achisoni* seeks to utilise the power of *tikutha* (we perish) in the absence of the accompanying *balala! balala!* (the concrete activity preventing said *tikutha*. There are inadequate resources and, except for a few elites, people can no longer flee to better pastures.

Given the lack of an epistemological compromise between the traditions exploited and the reality, scientific or otherwise, of HIV/AIDS, *Mauthenga achisoni* may not evoke the responses expected. In an atmosphere of misery, high death rates and despondency, casual sex becomes an even more popular pastime: *mwendo kumangothyoleratu* (make hay while the sun shines). To be effective an equally forceful constructive and pragmatic programme promoting safe sex should perhaps follow programmes like

³⁶⁴ The Malawi Broadcasting Corporation has always been a highly controlled state radio station (Article 19, 2000).

³⁶⁵ I am grateful to Patrick O'Malley for drawing my attention to the fact that the first Irish language radio station, in 1973, had a similar programme. It too was a useful community-building tool.

³⁶⁶ In 1996, when MBC was the only national radio station, 93% of men and 76% of women received their information about AIDS from the radio (MKAPHS, 1996). In 2000, the MBC has a 90% monopoly of all radio listeners.

Mauthenga. But it does not. The formative and normative power of this programme, in the traditional sense is immense. It bolsters communality, ensures central governance's caring nature is enhanced and brings the rural and urban sectors of society (enhancing traditionality) together; all for the price of a half hour radio slot.

Earlier we noted the use by the state of *ufiti* discourse in *Nkhani za maboma* and in other contexts. In this section we have shown that the dynamic between poverty and unmet needs produces a gap between aspiration and reality. Driven by tradition and theoretical education this favours the maintenance of cultural traditions appropriate to the socio-economic environment. We have shown that there is also a strong imperative to appropriate, and thus perpetuate indigenous cultural traditions as a tool for maintenance of communal and state order. These processes contribute to communal and state socialisation. We next consider how students become socialised, directly and indirectly, with reference to HIV/AIDS.

6.3 Some communal modes of socialisation

Having shown that traditional socialising forces, in the general and specific sense, are still strong in the Malawian context, in this section we seek to show how the socio-economic and other imperatives interact to produce a communal socialisation.

6.3.1 Literature review

Socialisation in traditional Malawian culture is through the family and/or extended family (Cf. Read, 1956: 68 –83), Peltzer (1987: 11 - 20). African Traditional Religions (ATRs), Muslims and Christians all stress family values.

One of the crucial points of this study is: Is this traditional socialisation also applicable to school students in respect to their medical socialisation? In my survey, most students partly answered this question for me by citing parents most, and family members second, as those responsible for first introducing them to the traditional practitioners (Table 24). The question was: Who first took you to a traditional medical practitioner?

Table 24

Question: Who first took you to a traditional practitioner?					
	Parents & Family	Others	Never been	No answer	Total
Site:					
Primary School:					
St. Martin's n=57	47%	07%	14%	32%	100%
Bwaila n=33	58%	06%	21%	15%	100%
Secondary School:					
Mangochi n=42	36%	10%	21%	33%	100%
St. Michael's n=59	20%	02%	14%	64%	100%
St. Mary's n=29	13%	04%	52%	31%	100%
Masongola n=32	38%	06%	28%	28%	100%
Zomba Cath. n=39	58%	00%	13%	29%	100%
University:					
1 st Year Phil. n=14	07%	00%	14%	79%	100%
1 st Year Eng. n=33	21%	27%	00%	52%	100%
2 nd Year Biol. n=23	48%	09%	09%	34%	100%
2 nd Year Th. n=21	38%	10%	05%	47%	100%
3 rd Year Th. n=10	30%	20%	20%	30%	100%

The table shows that, at all sites, parents retain an important role in introducing their school going students to medical services. The higher figures for ‘Others’ for the First Year English and the Third Year theology may reflect previous boarding school patterns where others may have introduced them to practitioners.

Socialisation, in the rural contexts involves various phases, some of which are associated with instructions in sexual matters (for example, in some rituals, how to sexually please a man/woman) and preparations for marriage. In the urban areas, some

of the specific rituals are missed, although, as noted in this Chapter some of these rituals are restored or reintroduced.

Read (1968: 70), in her study of the Ngoni, separates 'the knowledge of perceptions and information from the corpus of traditional lore about natural phenomena and their history' that young Ngoni were expected to become acquainted with by accepting social codes and by experiential learning in courts. In more recent years a number of papers, particularly student dissertation papers (See Chakanza et al., 1998: 30 – 38) have examined aspects of rites of passage in Malawi. Most of these have concentrated on puberty and death rites and on the Yao (perhaps because of the proximity of the Yao to Chancellor College) at the expense of other ethnic groups and other periods like birth, marriage and engagements, respectively.

Musopole (1998: 7-47) explicating the five aspects of the indigenous Malawi *uMunthu* concept of humanity separated it into five components: form (*thupi*), spirit (*mzimu*), community (*mudzi*), integrity (*chilungamo*), and work (*nchito*). He emphasises that the last two, can only result from social-nurture (*maleledwe*). Kaspin (1993: 34 - 57) noted that this social-nurture, in the non-Christian context, involves rituals, songs, initiation ceremonies, and dances - collectively called *mwambo* by the Chewa. We earlier noted that the use of some ritual and traditional ideas in popular music could disseminate some of these socialising ideas to youth who have not undergone formal socialisation.

But in the duality of Malawi culture it is necessary to examine how the two cultures, indigenous and western or modern, relate to our school going students. Peltzer (1986: 11) has suggested three types of 'personhood' in Malawi 'taking into account 'the various effects of colonisation and acculturation into account': traditional personhood/transitional personhood/western personhood. The person attending western schooling is, in Peltzer's model, supposed to move from the left to right of the model. Peltzer himself admits to the paucity of the western personhood. His transitional personhood is contestable on three grounds, the paucity and deficiency of Malawi education, the postcolonial demographic statistics showing a persisting rural preponderance of the population, and the lack of social mobility in Malawi, given the limited employment opportunities. Further, the concept, in its unidirectional mode,

presumes that Malawians can significantly detach themselves from their communal attachments to justify a 'western lifestyle label'; even the most elite Malawians would fail to pass the western personhood test given the context of their lives.

Peltzer's concept also seems only to take into account the aspirational aspect associated with those in schooling for adopting 'western lifestyles' (Cf. King and Martin, 2002) but ignores the other aspects of education, including simply to equip the learner with English and other qualifications to obtain good paid employment, rather than to become westernised per se. It is also worth pointing out that there are forces, which can produce a socialisation in a reverse direction to the traditional/transitional/western socialisation, a famous satirisation being in Mapanje's (1981: 59 - 60) *Making our clowns martyrs (Returning home without chauffeurs)*.³⁶⁷

This study suggests that a concept of identities shifting with time and space, while anchored mainly in traditional mode, is the appropriate model for many school-going students. We would argue that socialisation, in urban and rural areas, via schools and traditional channels like initiation and other practices lead to various degrees of hybridity around the core indigenous traditional culture. But many school going Malawians achieve a functional cultural duality which enables them to move from traditional culture to the 'westernised' urban culture of Malawi. Few achieve complete westernisation. Only a Malawian with no residual extended family or living abroad could, in the current cultural context of Malawi, approach western personhood. Given the prevailing concept of *umunthu*, hybridity and duality are the more sustainable outcomes.

6.3.2 Hybridity, socialisation and modernity

A feature of socialisation observable among school going youths in Malawi involves the process of reciprocal peer socialisation. Due to the process of institutional and peer hybridisation those attending primary, secondary and university education,

³⁶⁷ This poem addresses the theme of the fallen elite returning to 'the poached reed-huts you left behind... these stunted pit-latrines where only the pungent whiff of buzzing green flies gives way...' (Mapanje, 1981: 59).

despite not necessarily abandoning their own ethnic beliefs, may show more similarities in outlook with other youths from different ethnic groups. This is in line with the concept of one culture and another giving birth to a new entity that is different but also naturally retains the identities of its origins (Portella, 2000).

Thus, like the ethnic groups in urban USA, while most teenagers may identify with and follow features of common pop, hip-hop, dance or rap culture, subtle and significant differences may nevertheless be evident as between Puerto Rican, Hispanic, Italian-American or Afro-American groups.

In the United Kingdom, the same difference patterns are detectable between Scottish, West Indian or Welsh youth groups. In popular culture the young are syncretising traditional and modern western forms to produce their own socialisation paths separate from traditional or formal educational ones. This has been observed in Nigeria (Abdullah, 2001) and South Africa (Peterson, 2001). Peterson (2001), for example, sees *kwaito*, a new urban dance music, as ‘eloquent testimony of the agency of young black people and the ways in which they humanise, narrate and critique the harsh and hostile urban environment in which they find themselves. Some of this reciprocal youth socialisation is seen among those who establish new churches (van Dijk, 1998; Adogame, 2001).³⁶⁸

For our purposes, what is of relevance in this reciprocal peer socialisation is the distillation of diverse accurate, ambiguous and incorrect attitudes facilitatory of HIV spread in some of these common popular cultural threads (Cf. Baylies, 2001).³⁶⁹

Only an adequately critical education can help these hybridised youths achieve the ability to attempt to sort out these conflicting socialising messages.

³⁶⁸ van Dijk studied Malawian youth; Adogame’s paper provides a pan-African perspective.

³⁶⁹ Significantly, a common feature of youth culture the world over is their tendency to be ‘bored’. Among Malawian youth who have gone to school a new word *kubowa* (to be bored) is in common use. While their counterparts in the west may use IT tools and games, sports facilities, television and other means to reduce the boredom, few Malawian youth have access to these.

6.3.3 The significance of modes of communications in establishing and reinforcing Social Norms, Attitudes and Beliefs.

6.3.3.1 Orality

The thirty-six years of the postcolony have not reduced the oral nature of Malawi culture, on the contrary.³⁷⁰ As already demonstrated in Chapter Five, traditional story tellers, actors and popular musicians fill a greater part of the public sphere than do written text sources like books, journals, magazines and newspapers.

In their introduction to *Land of fire*, Shoffeleers and Roscoe (1985: 7-13) quote Hallowell (1947)

The study of oral literature ... could help significantly with the investigation of human psychology and the adjustment of the individual to his culturally constituted world.

In the HIV/AIDS discourse, this is a relevant observation. One way of filling the public space is via plays, in urban and village ‘theatres’.³⁷¹ These plays are now, belatedly, interrogating the HIV/AIDS and poverty dynamic. Under the one party era most theatre was used either for ‘development’ (*chitukuko*) or for the purposes of praising Dr Banda (Kerr, 1995; Chimombo et al, 1996).³⁷² Health extension workers and ordinary playwrights write plays used for health promotion as well as entertainment. Consequently there is often a mixture of artistic licence, health promotion and polemic in broadcast plays. For example, in the play *Chiweto* (livestock) (MBC, 25/7/00), a rat that has been used by a witch as a *fisi* to “get things for us” is killed. The owners of the rat protest vehemently at the destruction of their “livestock”. At the end of the play there is no attempt at explaining whether the play was comedy or a serious reflection of reality. The ambiguity lets listeners form their own opinions. Like *Nkhani zamaboma*,

³⁷⁰ Despite the introduction of free education, in 1994, illiteracy levels remain high (NSO, 2000); UNIMA/SARDC, 1997. The electronic media of radio and radio cassettes promotes orality.

³⁷¹ Theatres are often ‘under a mango tree’, but increasingly community and school halls are used.

³⁷² During the transition to multiparty this theatrical tradition was appropriated by the opposition to deconstruct Dr Banda’s regime.

such plays do legitimise *ufiti* discourse.

The youth in Malawi are exposed to *ufiti* discourse phrases even if belief in traditional causality concepts is not intended: for example: *kuliputa tsoka* (asking for it) and *apandiye ufiti* (this is witchcraft) to explain a problem of great magnitude, e.g. excessive AIDS deaths. These phrases may be used in ironic vein.³⁷³

In the female arena, the activities within *kumpanda* (house compounds) and at *pamtondo* (women at the mortar, pounding maize) provide other opportunities for disseminating orally acquired information, which may reinforce or dislodge beliefs about HIV/AIDS. Incidentally, radio programmes for women, which I monitored, had, from a medical perspective, high quality contents of HIV/AIDS awareness material. However, these programmes also went for the aspirational solutions; even programmes directed at rural areas advised solutions that would be difficult to implement in the rural context because of material and/or traditional/cultural reasons.

In a still largely oral culture like Malawi the public sphere ideas entering this public space via the spoken word, stories, songs, dances, village theatre and popular music are often contradictory. Thus Maluwa-Banda (2000) showed, as my survey did, that secondary students had ‘adequate knowledge about the basic facts about AIDS, [and] the transmission of HIV...’ He also noted that this knowledge about HIV was found to co-exist with ‘some misconceptions’. Maluwa-Banda (ibid, 2000) noted that friends were cited as the major influence on students’ decision to have sex, with the school [peers] being identified as the preferred source of information on sexuality, confirming the reciprocal peer socialisation. However, his assertion that they had ‘adequate knowledge of how they can protect themselves from being infected’ is contestable. The students had theoretical knowledge on abstention, yes, but not on safe sexual practices. Further, they have the knowledge but many do not have the means.

Noting the role of orality in student and general population discourses in Malawi, this study argues for the concept of an oral and musical public sphere (Cf. Habermas, 1989)

³⁷³ Interestingly, this has connotations of ‘wicked’ as now popularly used by – originally – black UK youth.

discourse as a locus of contesting and convergent received, perceived and emerging cultural ideas and concepts. We suggest that, in postcolonial Malawi, orality and popular music perform an important two-way role in disseminating cultural modes of thoughts, beliefs, and practices between the individual and this public sphere; functioning - apart from its entertainment role - as a tool of cultural continuity, re-invention, hybridity formation, diversity and social-cultural reproduction and construction. This role will, in the short-term remain important in the health promotion sector. If positive and developmentalist health promotion discourses relevant to HIV/AIDS are to compete with negative messages that abound the positive discourses should be located in the oral and musical sphere.

The oral/literature interface

Some of this oral discourse is now being carried over from the oral tradition into the written arena. Shop names, minibuses and houses may carry names, which express the person's viewpoint. Some of these are old while others are of recent origin. Examples include: *Angoni satha* (The Ngoni cannot perish); *Zonse ndi moyo* (Health is the key to all success); *Thukutha langa* (I sweated for this enterprise); *mufa nayo nsanje* (you will die because of jealousy); *mwai wathu* (our good luck); *mufela zaeni* (you will die for other people's gain). This discourse opines, justifies, blames, critiques and reaffirms. It is related to work, social relations or competition (Chakanza, 2001: 28 – 29). And, as we saw in Chapter Five, some of these discourses are entering the written arena, with *Nkhani za maboma* like stories increasingly being found in the newspapers and magazines. From the perspective of this study, this is traditionality invading modernity.

Some elements of this oral public sphere enter the written arena, continuing this subtle communal socialisation process of the literate. The myth surrounding the *fisi* (hyena) concept, for example appears regularly in the written media. An article in the *The Daily Times* 4/8/00 gives an example:

[Hyenas] 'rampaging' in Ntcheu have been blamed on witchcraft. One parent who had two children attacked by a hyena 'attributes all this to the work of witchcraft. "But who ever I angered or quarrelled with should simply have come to me and I would have apologised other than

victimising my innocent children”, rails Joseph Wanje’.

Even though, in the article, Dr Fulata Moyo of the University of Malawi gave an explanation ascribing this to real hyenas displaced by environmental degradation, and thus invading villages, the debate continued:

Chief Eneya, of Mphate, however maintains that these are fake hyenas belonging to some hardhearted people who use the beasts to victimise their enemies. [He once saw a hyena running away, on being chased, on two legs]. “Do you call that a hyena?” Witchdoctor Jonas Chasiya ‘who operates at Mphate market says ‘it is foolhardy for anybody African to undermine the work of witchcraft’ (ibid, 4/8/00).

My examination of the press during July – August 2000, showed many articles in this vein:

A five year old, Lulu Mvula, was alleged to have become a witch after being initiated by a neighbour, Mai Mtira. The witchcraft was ‘detected’ by a *sing’anga*. (The *Daily Times*, 21/7/00).

On 4th August 2000 the *Malawi News* reported that the game between Bata Bullets and Wanderers, Malawi’s two top football league teams, was on 29/7/00, delayed by half an hour ‘because of suspicion of juju’. The reporter, Rex Chikoko, titled his article *Juju wanyanya ku Malawi kuno* (Too much juju here in Malawi).³⁷⁴ When used orally, these *ufiti* discourses are rarely contradicted, even by Christians and other westernised elites. But when messages meant for the oral domain are translated into the print medium the contradictions between the messages soon become apparent. For example, the government’s HIV/AIDS strategy is, in the messages delivered within the same week,³⁷⁵ seen to cater differently to internal and external fora.

28/7/00 *Daily Times* ‘Following the directive from President Bakili Muluzi last Sunday, to arrest sex workers and their male counter parts loitering in the night, Police in Blantyre have started arresting them’.

3/8/00 - 9/8/00 *The Enquirer* The Home Affairs Minister tells a Southern African Regional Police Chiefs Cooperation Organisation that police chiefs should not hide the severity of the HIV/AIDS problem from their

³⁷⁴ The *juju* phenomenon was common in school and senior (professional) Malawian football in the 1970s and 1980s. A famous *juju* practitioner ‘Hitler’ was believed to be able to influence the result. This form of *ufiti* is, as shown by the name, a West African import.

³⁷⁵ In oral vein.

officers.

At the same time, cartoons exploit orality and traditionality to perpetuate this ambiguity.

Nation 3/8/00. In a cartoon comment on the President's order 'removing prostitutes from all hotel environs' the cartoon character *Zabweka* is seen remonstrating with a policeman preventing his 'wife' from entering a hotel saying: 'Well you may know her as a sex worker, but I know her as an ex-sex worker and she's now one of my many wives'.

Here traditionality, on its own oral terms, is seen to invade modernity, promoting ambiguity.

6.3.3.2 Music

As demonstrated in Chapter Five, popular music carries a large social content. Indeed, outside politics, popular music in Malawi is often pregnant with metaphors, symbols or cultural signifiers.³⁷⁶

It is often tempting to judge African popular music, due to the multiplicity of languages and its dance orientation, by its form or style rather than its content. The meaning may thus often be ignored.

Nketia (1982: 241 - 245) made an early recognition of the inevitable postcolonial adjustments to aspects of traditional African music 'because of the close integration of music and social life'. In Chewa, for example, *chamba* denotes either 'dance' or 'custom or tradition' (Malekebu, 1952). As modern mass communication methods partly replace or duplicate rituals, village dances and other forms of community performance, Nketia's (1982: 245) 'problem of transfer of function' is manifested as partly one of musical hybrid formation, as well as the transfer of musical function in both context and

³⁷⁶ Malawian recordings can be found in the ILAM (International Library of African Music) collection (Rhodes University, Grahamstown SA); the Pamtondo series (Glasgow); Moya Malamusi's (1999) CD *From Lake Malawi to the Zambezi* Frankfurt: PAMAP 602; and the UNESCO CD D 8265 (1991) *Musical traditions of Malawi*. Kubik et al (1987) suggest a culturally based framework for analysing Malawian music.

medium. It is also manifested by the appropriation of traditional forms and contents by popular musicians. We see these hybrid styles or appropriated forms in their new guises as but foundations that carry the meaning in a way still communally identifiable and danceable somewhat akin to Coplan's (1985) urban South African findings. In the particular case of Malawi, the limited urbanisation and the continuing 'rural' nature of the cultures in the peri-urban areas make the transfer of function more a matter of context than content.

It is suggested here that popular music has inherited some of these socialization functions, even among those who do not go through ritual initiation ceremonies. This is of significance in the context of an oral culture where some of the rural, urban and peri-urban population has lost some of the formal ritual rites of passage and formative means of *maleledwe*.

Malawian politicians, perhaps acutely aware of the power of music, attempt to invade and exploit this musical public sphere. At the 1978 independence celebrations at Kamuzu Stadium, Banda, his cabinet, the cream of elite Malawi, Christian and Islamic leaders, diplomats and the general public all watch and listen with apparent enthusiasm and 'agreement' as the Dowa Malawi Congress Party women, the *mbumba*, dance and sing as part of their praise of the leadership's policies

Muwalo ndi woononga, (Muwalo is a confusionist)
Gwede ndi woononga, (Gwede is a destroyer)
*Anthu otere ayenera kuphedwa. (Such people must be killed).*³⁷⁷

These appropriated and transformed musical forms as sung by women were politically potent, reducing men to paralysis (Cf. Mapanje, 1981: 12 – 13). Forster (1994: 491-20) and Muyebe & Muyebe (1999: 236) have noted this 'normative' complicity in popular political music. The political 'normative' complicity, associated with disposable political power tends however to be transitory, quickly replaced in the public sphere by

³⁷⁷ Albert Muwalo, a former MCP Secretary General, and Focus Gwede, a former head of the Police Special Branch, had been arrested for allegedly plotting against the government. Dr Banda and the MCP regime believed in the death sentence for serious criminal and political offences.

a new normative order.³⁷⁸ We also suggest, therefore, that it is the non-political social and cultural symbols, signifiers and meanings - themselves paradoxically embedding elements of tradition and change - that linger longer in the public sphere. However, it is the expensive and distracting appropriation of the public space by politicians that minimizes the use of this space for health promotional activities via music and orality. For example, even as Muluzi spoke of encouraging HIV/AIDS awareness, he was by 1998, actively encouraging women to dance for him, in the Banda manner (Chirwa, Personal communication, 23/6/1999).³⁷⁹ And by 2001, the highlight of the Republic celebrations was the performance by a 'yellow' *mbumba* performer who sang the praise *AMuluzi amenewo. Lyo! Lyo! Lyo!*

In terms of socialization, popular musicians receive ideas from their parents, peers, at initiation and ritual ceremonies and in other ways. These musical ideas are appropriated in whole or part and recycled in their compositions. They also compose original reflective songs, which are influenced by their cultural experiences and socio-economic, political, educational and religious influences. Thus, in the postcolony we can identify several phases in the construction of the current musical public sphere, each phase influenced by prevailing socio-political and other concerns:

- An early attempt at creating a sophisticated African musical sphere based on syncretic music and lyrics in line with educated thinking, beginning in the late colony (after the Second World War) by musicians like Wilson Makawa, Luka Maganga;
- A corruption of this theme by musical artists, who while playing to the sophisticates were largely rural or peri-urban dwellers with their own socio-economic agenda (after 1960). These artists, like Enock Evans, used the sophisticated form without necessarily modernising the lyrics;
- A rejection of both ideas by the rural and peri-urban artists who, after 1967, appropriated elements of foreign music, like reggae, as a performative template but preferred indigenous lyrics and themes influenced by the context of their

³⁷⁸ For example, the same lyrics that praised Banda now praise Muluzi; and a few of the 'staunch' women who sang for Banda, now praise Muluzi. Banda's former praise songs are now used, with little lyrical amendments, to praise Muluzi, the new *pamtunda wadziko* (head of state).

³⁷⁹ Muluzi and Verah Chirwa, a women's rights activist, publicly disagreed over this issue.

lives;

- The eruption of all forms and lyrical contents after the removal of *mbumba* and political praise music from the MBC in 1993.

One could now add a postscript to that sequence namely

- The re-emergence of music based poets and *alangizi*³⁸⁰ in the multi-party era.

The latter category, a reaction to the political corruption and disappointments of the multi-party politicians, shows that, even in pop format lyrics can be highly traditional, educative or inspirational. Paul Banda (*Nation* 26/6/97), one of Malawi's premier *alangizi* musicians and producers provocatively declared:

I laugh when Malawians sing about love. Leave that to the Americans. They are happy we are not. People [here] want to listen to issues.

Banda was referring to the need for music in Malawi to be 'socially responsible'. His implication is that this popular music is about serious issues. When Paul Banda made the statement, it may have been appeared controversial and 'over the top'. But five years later, when Malawi is gripped by famine and the Minister of Agriculture, Aleke Banda has conceded that HIV/AIDS has taken such a toll on agricultural extension workers that the Ministry is recruiting emergency field assistants and also exploiting music to improve agriculture, Paul Banda's perception of the need to use music to 'sensitise' the population, takes a different light. Interestingly, popular musicians had used traditionality to ensure a voice for themselves, by invoking the role of *alangizi*, a role used by elder people in traditional culture to give critical or formative advice. This is done using riddles and proverbs, as noted with *Mtedza subala nzama* (peanuts do not beget chick peas).³⁸¹ It demonstrates the formative and normative content of *alangizi* music, as well as the fact that public sphere traditional concepts are not necessarily rigid and closed; ideas can be embedded, dislodged, renewed... and they can surprise.

³⁸⁰ In traditional culture these are counsellors/advisers whose advice is based on experience. During the Banda era, such artists were rarely seen in public. The relative youth of the *alangizi* compared to earlier musicians like Chechamba and Ndiche Mwalale is noted.

³⁸¹ Cf. Kasambwe Band (1992) *Ndilibe Ambuye*.

Popular music shapes or reinforces cultural ideas in this public space and this may influence even those not exposed to formal initiation or other rites of passage into specific cultural groups. Now denied the pre-colonial political-medical-social construct of its former and more formal predecessor this rural inspired public sphere can only advise; what an individual obtains from this space ultimately depends on the individual's social, cultural, religious and perhaps political circumstances. In relation to HIV/AIDS discourses, these influences can be ambiguous. And ambiguity can be as effective as it is overwhelming, as we noted in Phiri's *Tikutha* (See Appendix 1).

The dangers of ambiguity in a multi-factorial public space are obvious. It is such ambiguous discourse that empowered some traditional healers to regard AIDS as a curable disease.

6.3.4 Reinforcement via the electronic media

63% of secondary school students surveyed by Bandawe (1992) heard about AIDS from the radio; with medical, relatives, newspapers, and teachers trailing far behind as the other sources of information (Cf. National Statistical Office, 2000b). We have already noted a number of programmes relevant to the HIV/AIDS discourse, including *nkhani za m'maboma* (district news). Second, a programme on Radio 2, called *Tips for life*, which deals with Adolescence and Sexuality.³⁸² The programme again demonstrates the high aspirational content by promoting 'early and effective sexual education and early and effective contraceptive advice' using a conventional western 'informed choices' approach. In this form it is only of use to elite urban and peri-urban teenagers, but of less so for *anthu wamba* youths, for whom the only useful tips would be abstention.

Asamala moyo, a vernacular equivalent, sponsored by the Ministry of Health, addresses issues of teenagers sexual awareness, how they receive these messages whether from their peers or parents. It discusses the different socialising routes taken by male and female adolescents: females, while also consulting their peers, tend to get advice from

³⁸² The boys' equivalent of the first menstruation, in Malawi, is the first wet dream.

their elders, especially after the first menstruation. Following this event many are given instructions by elders akin to those given in *chinamwali* ceremonies. Boys on the other hand tend to be reluctant to inform their elders. Geloo (1999: 3) found a similar pattern: males were more comfortable discussing sexual issues with male peers, while girls were comfortable discussing most sexual issues with both males and females. Consequently, unlike the girls' socialisation, boys' sexual awareness information depends on the knowledge of their peers. Again *Asamala moyo*, although informing, does not have practical solutions for rural youth.

The net effect of radio programmes like these, which are based on western strategies for HIV/AIDS prevention and control and for which mainly urban or elite youth can access resources, is to socialise and entrench the differences between rich and poor; and also between those that know and can access resources and those that know and can only aspire.

6.3.5 Death: the Ultimate socialiser

Msiyeni, maliro ake adzalira yekha (Let him be, he will mourn himself)

In Malawi where no formal social welfare or security systems exist, except for a tiny few, funeral costs have always been a shared communal burden, both in rural and urban areas. In urban areas, employers used to offer considerable assistance. With the advent of HIV/AIDS, the high number of funerals has led to employers limiting their assistance and families, both rural and urban, are increasingly unable to bear the burden of funerals.

In rural areas the communal experience still largely pertains and people help each other. This imperative to preserve the communal aspect surrounding death has led to more 'traditionalising' of terminal illness and death, in order to fulfil the rituals of communality.

In urban areas, where burial costs may reach K20,000 (Chakanza, 2001: 28), various initiatives are being tried in an effort to make funerals affordable. These include: the

formation of burial societies, dependence on fellow church members, dependence on people from one's own locality or home of origin and repatriation of the deceased to the village of origin.

In all cases, in the absence of government solutions, this is, as in the rural context, largely an imperative for more, not less, traditionalisation of urban culture based on networks of support.

Thus we note that the paradoxical legacy of HIV/AIDS, a 'western scientific disease', in the Malawian context is a restoration of traditional communal values around funerals both in the urban and rural settings.

6.4 Conclusion: Impact of contextual cultural socialisation and discourses on health promotion messages with reference to HIV/AIDS.

Prevailing cultural attitudes, as we have noted in chapters, Four and Five, impact on the HIV/AIDS awareness and prevention messages. This may occur through a number of mechanisms.

- The belief in a given cultural norm. For example, students from polygamous cultures may fail to view multiple girl friends as 'abnormal', even in the context of HIV/AIDS, as seen with Zabweka above (6.3.3.1).
- The actual belief in *ufiti* or other malign forces causing disease may lead to the ignoring of obvious risks.
- The belief in the protective powers of *kukhwima* may lead to behaviour that puts people at risk of HIV/AIDS.
- The belief in the powers of *sing'angas* to treat STDs may undermine the role of STD clinics.
- The belief in the treatability of HIV.
- The confusion between safe sex and abstinence.
- The formulation of ambiguous indigenous responses to HIV/AIDS informed by *ufiti* discourse and other 'misconceptions'.
- The continuation of cultural practices promotive of HIV/AIDS.

- The dilution of the effective use of western medical knowledge through ambiguity.
- The promotion of an uncritical medical duality in which any available medical resource is utilised.
- The subversion of its own developmentalist agenda by the state through using *ufiti* discourses for socio-political agendas.

These and other factors, in the case of HIV/AIDS, interact with socio-economic conditions to create

- Ambiguous discourses which attempt to bridge the gap between reality and aspiration
- The early experiential separation in school students of 'book' from 'realist' knowledge, in such a way that education becomes a theoretical rather than practical tool for many; it is thus later easy to disengage 'book' knowledge from pragmatic 'knowledge'.
- An atmosphere where the value of life, often perceived as risk-taking, becomes reduced.
- A cultural alibi (*ufiti*) discourse covering government, communal and personal inactivity and denial.
- A circular dynamic between aspiration, reality and action, where traditionality, rather than modernity usually wins.

For example, having failed to cure AIDS and being continually presented with it in the face of western medical failure, traditional discourse can be seen to be reformulating itself into a traditionality of a social constructive model. The discourse is appealing to the community to respond as such. As *Tikutha* shows AIDS is now specifically 'a communal problem', a far cry from *Watenga AIDS iwe* (you have contracted AIDS). This communal theme is also a theme taken up in Ben Michael's '*Tilire tilire*' (Lets all cry).³⁸³

Tilire tilire, let's all cry!
Not for the dead, but for ourselves!
Tilire tilire, let's all cry!
Not for the dead, their turn is gone!

³⁸³ Michael B *Tilire* High Density Records HDBM5010, Blantyre, Malawi.

This public sphere seems to be formulating a response to HIV/AIDS, a response much more vibrant than the government one. This response perhaps recognises the 'scientific' cause of that epidemic, many of the people at the *Tilire* funeral had 'slept with the same person'. There is also an understanding of the expense and failure of curative medicine in, for example Chaphuka's *Ndichiritseni* ([God] heal me). The response being shaped appears to utilize communal ideas of prevention. It resembles the old social construct, not based on the deceit of the man in *Tikutha*, who exploits 'causality traditions' when his town activities disease him, but on *how things were in the old days*.

It is interesting to note that one current, and apparently most popular health promotion exercises, uses appropriated traditional songs to promote Chishango condoms.³⁸⁴ One jingle is used both to preface and in the middle of plays that deal with sociological matters. The juxtaposition of the play and the 'traditional' sounding advert jingle is effective.

*Inu anyamata ndi asungwana pewani chiwerewere;
koma kusadzisunga kwakula atsikana chenjerani
mutha kugula chishango...
asungwana chenjerani chitetedzo ndi cha tonse...
(Boys and girls avoid promiscuity; but, as failure to
observe abstinence is now a growing problem, girls beware
you can buy condoms...
Girls beware, prevention is for us all...)*

The song evokes a traditional rurality even for urban plays. Interestingly, the jingle concedes what religious organizations are reluctant to admit: that every one can resort to abstinence. The jingle does this by suggesting that the observance of abstinence is declining, girls should 'beware' and prevention is 'for us all'. Although PSI, the company that markets *Chishango* condoms in Malawi denies using culture as a marketing strategy, two factors contradict this assertion. First, the trade name *Chishango* (shield) is illustrated using a warrior's shield, this resonates with protection and cultural resistance all at once.³⁸⁵ The suggestion that 'abstinence is now a growing problem' plays on (without re-inventing it as 'it has never gone away') the myth of an

³⁸⁴ In terms of rhythm and vocal arrangements.

³⁸⁵ As in South Africa, the spear and shield remain strong and vibrant cultural continuity symbols.

older more perfect order. This can be seen as a clear appeal to traditionalists and those religious organizations that are not in favour of condoms, especially as the first line clearly appeals to the youth to ‘avoid promiscuity’. The same song is repeated in Yao. The advert does not yet address some of those aspects of the ‘old ways’, which are promotive of the epidemic. But compared to earlier attempts, in the context of this public space, it is an advance.³⁸⁶

The Malawi Police Orchestra’s (c1995) *Kunja kuno kwaopsya* also uses a communal approach:

Anyamata ndi asungwana eh! (Boys and girls!)

Azimai ndi azibambo eh! (Ladies and gentlemen)

Tonse tili pankhondo ndi Edzi eh! (We are all at war with AIDS)

Zipolopolo zao ndi tizirombo eh! (Its weapons are the viruses!)

Pothawira peni peni tilibe ife (We really have no where to run to)

Zishango zathu zikhale makondomu eh! (Our shields are condoms eh!)

Masiku ano kunjaku kwaopsya (Nowadays it is dangerous out there)

Tizirombo tikukhala m'magazi (These viruses are living in the blood)

Masiku onse tikulira maliro (Everyday we have a funeral)

Nkhondo yomwe ndikunena ndi matendawa (The war we are talking about is this disease)

Madotolo akuti mankhwala kulibe kuchipatala (Doctors say there is no hospital medicine)

Asing'anga akuti mitengo kulibe uko ku dondo (Sin'ganga say there are no herbs for it in the forest)

Opezeka ndinthendayi tiwasunge bwino (Let us take good care of those who are found to have this disease)

Pothawira peni peni ife tilibe eh! (We have really nowhere to run to!)

³⁸⁶ Kondowe et al. (1999: 15) found that Population Services International (PSI), who sell *Chishango* (a brand of condoms) were less keen to integrate cultural issues into their programmes. The implication was that they prefer to promote *safe sex* (involving condoms), rather than *no sex*, which does not involve condoms.

Here the epidemic becomes a war against the community, one in which boys, girls, ladies and gentlemen all have to fight. AIDS' is projected, in the plural, as an attacking enemy using the 'bullets' of viruses. Conquest, if 'we are not careful' is inevitable as there is 'nowhere to run to'. We are reminded that some of the invaders have already taken residence in the blood. In the absence of the possibilities of *Balala! Balala!* (running to new and safer pastures) the only alternative is to stand and fight using protectives. And, as in the old order, take good care of those who fall victim to the epidemic. Such imagery is often lacking in western derived health promotion discourses that are targeted at school students.

The dangers of an uncritical duality and ambiguity are that people move in and out of behaviour patterns, which, while appropriate in one mode, are dangerous and risky: for example the university student who uses a condom with his urban girl friend, but has contracted a *chokolo* inheritance at his home on the death of his brother and does not use a condom in the latter situation. In this regard, the suggestion by, among others, Amos Chigwenembe (2000), HIV/AIDS programme coordinator for World Relief Malawi, a Christian NGO (*Daily Times*, 2/8/00), that equipping children during socialisation with accurate information on the HIV epidemic could help protect young ones from its exposure is a welcome advance. Chigwenembe emphasised 'positive parenting' via the family. However, in Malawi many children are socialised by uncles and aunts. And, although addressing the many ethical and moral aspects of HIV prevention, in the current HIV/AIDS awareness campaigns the aspects of family values exploited are those of sexual abstinence, and monogamy. Chigwenembe's suggestion therefore still falls on the resources angle, producing informed but ill resourced children.

CHAPTER SEVEN

Thesis implications, suggestions and final conclusions

M. D. Z. age 14 form 2, St Michael's Girls Secondary school (905): 'If you really can't [abstain], then use a condom'.

7.1 Implications and suggestions

This study has implications for all those engaged in HIV/AIDS prevention work in Malawi among those attending school, and therefore with the future leaders in all formal sectors.

The thesis has demonstrated the influence of localised practices on school attendees via socialisation in the village and at school; the deficiency of western medical services in rural areas; and the resilience and transmissibility of localised practices and beliefs via orality, music, family and peers. These beliefs have been shown to influence student attitudes to HIV/AIDS directly and indirectly as aspects of the history of HIV/AIDS in Malawi have demonstrated. We also noted that these school attendees in Malawi might be influenced by the contents of the oral public sphere. While the oral public sphere in Malawi is and remains stronger than the literate one, it is best to remember Mazrui's (1990: 140) controversial statement:

Oral tradition is a tradition of conformity, rather than heresy, a transmission of consensus rather than dissidence.

In Malawi, contrary to Mazrui's assertion, orality can also produce hidden dissidence and open ambiguity, permitting localised practices to thrive.³⁸⁷ But where health promotion messages are being 'corrupted' by orality towards youth attitudes that are promotive of HIV/AIDS, then much of the conventional health promotion efforts are

³⁸⁷ In the political arena orality certainly produces conformity in Malawi. Traditionality is often recruited to produce a system of punishments and rewards for dissidence (Mphande, 1996: 80 - 101).

being wasted. This study suggests that positive HIV/AIDS discourses need to be deposited and situated in the oral public sphere so that health and developmental messages can compete with the formulations from the 'tradition' fed sector. In the fight against HIV/AIDS, all prevailing national, urban and, particularly, rural localised socio-economic constructs and realities should be taken note of in any theories of how to deal with the HIV/AIDS epidemic among the youth of Malawi.

In this regard, I would like to see further work in this area involving, for example, studies that:

- More fully examine the exploitation of the public sphere for HIV/AIDS prevention
- Investigate localised interventions in specific medical/cultural interfaces, for example *nsondo* or the treatment of infertility using *afisi* (nocturnal anonymous sexual surrogates)
- Result in programmes that offer life-skills that enable the acquisition of safe sexual practice knowledge appropriate to both urban and rural areas
- Result in strategies to reduce the gap between theoretical school knowledge and the 'practical' knowledge from socialisation in the community.

The last being a key consideration in any educational, health or developmental discourses that seek to place Malawian school going students on a path towards more practical modernity rather than a pragmatic traditionality. The former implies a higher degree of choice within limited resources while the latter implies abandoning most 'book knowledge' and turning to localised traditionality.

7.2 Conclusion

Recently Malowany observed of the history of medicine in Africa,

While medicine looks at patients, doctors and treatments, the epidemiological and historical study of disease extends this gaze to the community at village, national and regional levels. Combining science, medicine and epidemiology into a historical framework permits an exciting exploration of variation in the disease itself, the disease experience, the local context and the response (Malowany, 2000: 348).

This thesis has attempted this task. It has noted that many current HIV/AIDS programmes are predicated on a socio-economic 'westernisation' of African cultures. Given the ontological reality this study has demonstrated in Chapters Five and Six, it can be argued that these programmes are likely to be only partially successful, leaving reservoirs of localised HIV 'epidemics'.

Mazrui argued that culture 'provides lenses for perception and cognition, motives for human behaviour, criteria of evaluation, a basis for an identity, a mode of communication, a basis for stratification and the system of production and consumption'. If we follow this definition, from the HIV/AIDS perspective, a number of considerations arise. First, a sexually transmitted disease with individual and communal sequelae is clearly a cultural problem. Solutions to it should involve cultural considerations. Second, the HIV/AIDS control campaigns are, in Malawi, at best, currently aimed at the 25% or less of the population who can afford to follow the 'condom and abstention' paradigm. And even if the donors or the Malawi government itself provided enough condoms, the condom paradigm still has to overcome the 'sweet-wrapper' resistance (Cf. (Kornfield et al, 1994; Jimmy-Gama, 1999).

In the Malawian context and in the case of HIV/AIDS, then, from the foregoing historical perspectives (Chapter Two, Three and Four) alone, one can predict that to be more successful HIV/AIDS campaigns need to engage specific localised cultural practices. And if culture change is required, the site of significant cultural change and effect needs to be the localised cores of traditional practices at village level that had been impenetrable to authorities both colonial and postcolonial: for example, the initiation rites which include *fisi*, *nyau* or *unyago* activities; residual traditional birth practices, *kukhwima* and other socio-cultural activities which, for example involve degrees of incestuous or underage sex; *chokolo*; cleansing rites for widows and other practices that may involve sex with HIV infected people; the multiple use of instruments in scarification and hair cutting.

Indeed, history also hints at the constancy, resilience or 'conservative nature' of these societal traditions; conservatism assured by various mechanisms that 'permit while

resisting change' at localised and indeed national level. In the current environment, some sectors of the population, largely rural³⁸⁸ and subsisting at socio-economic modes sometimes reminiscent of pre-colonial levels, may feel under cultural attack from aspects of the western HIV discourse. Here the power brokers of tradition may consider themselves at risk. There will thus be an accelerated process of transmission of cultural knowledge from one generation to the next.³⁸⁹ As argued, in the case of women, at such times, cultural values are even more assiduously guarded. The falling life expectancy also contributes to earlier generational cultural transmission.³⁹⁰ This has implications for some school students. As argued earlier, in the case of women, at such times, cultural values are even more assiduously guarded. And if, in traditional medicine, as we have suggested, change is inspired by new and hostile challenges and occurs after experience and survival, we can predict that, given the localised nature, each entity structures its own response. But these responses will always reflect the socio-economic and cultural realities and possibilities.

Much of the discourse on HIV/AIDS has underplayed the role of socio-economic factors. When, for example McAuliffe (1994) notes that there is no evidence to suggest risk behaviour reduction even after people have recognised HIV she may be missing the point: Are these people, in the case of school students who experience dual cultures, at stage one of recognition in their 'western mode' or 'traditional mode' of their duality? In the case of the latter, their behaviour will appear risky to the western observer but logical from whatever traditional point of view – and socio-economic reality – is informing their behaviour. As we pointed out earlier, and in Chapter Four, risk-taking behaviour can only be seen as such if the people carrying out the behaviour are, firstly, aware of the causes and consequences of the risks they take and can, secondly, with practicality avoid them. In this regard, therefore, behaviour change is difficult where the socio-economic environment is inappropriate to that change.

³⁸⁸ The debates on physical urbanity versus social urbanity are relevant here. The thesis here is that in Malawi, the rapid 'shantytown urbanisation' is merely accompanied by the transfer of rural cultural mores and traditions to these new sites.

³⁸⁹ This is a phenomenon that occurs during epidemics, wars and other upheavals to ensure continuity of aspects of tradition.

³⁹⁰ This is already noticeable as 'clan heads' become younger as AIDS and other disease reduce Malawi's life expectancy, now thought to be about 40 years, as opposed to 46 fifteen years ago (Lwanda, M., personal communication, 3/8/2000).

McAuliffe's (1994) dilemma, in the example above, results from the problematic of basing strategies on aspirational western-based socio-economic achievements and substrates; this needs to be revisited. It is here suggested that more effective anti-HIV/AIDS strategies will combine the theory absorbed by students at school, their cultural context, the socio-economic context and - if the government chose to prioritise health - adequate appropriate resources to formulate practical and realistic solutions.

The postcolonial cultural dialogue - about identifying good aspects of Malawian culture, throwing out the bad and mixing the good aspects with elements of modernity - initiated by, among others, Dunduzu Chisiza (1961), and strangled at birth after Dr Banda's achievement of absolute power, experienced a thirty-year hiatus, from which it is just awakening. From the current HIV/AIDS perspective, it is how the relationship between culture, politics and medicine affects the resources available to HIV/AIDS prevention and the resulting action that is of relevance. In Malawi, these resources are firmly in the hands of the elite.

In the postcolony, the black elite, who took over power, after 1961, merely replicated the departing colonialists in their self-interested use of scarce national resources as McCracken (1977: 303 – 344), Mkandawire, M. (n.d.), Phiri, K (2000: 3 - 12) and others have demonstrated. Phipps (1972: 14 –15), barely eight years after independence, saw the government as being the main source of black enterprise:

At the moment the government may be the most important source of entrepreneurial actions. The charismatic leaders of the days of independence who mobilised the people to remove the colonial powers have now given way to the charismatic party and at the moment the political entrepreneurs are paramount. These may be the key figures for the future with an influence that could be constructive or destructive. As Nkrumah said 'Seek ye first the political kingdom and all will be added unto you'.

In the case of Malawi, sadly, the political hold on socio-economic resources, and hence

governance, became ossified under Dr Banda, and appears to have become even more tightly grasped by the business elite (Lwanda, 1996: 17 - 39) who succeeded him. This dynamic is crucially important because the majority of businesses in Malawi, as in most of the subsistence economies of Sub-Saharan Africa, are entirely resource extractive rather than sustainably productive. This induces a culture of short-term extraction by elites that often extends to government resources. This occurs at the expense of the health services.³⁹¹

One of the most 'modifiable' risk factors for HIV is STDs, but even these are difficult to modify where one of the most powerful political and economic forces is sex. Heterosexual sexual power in its association with dominant masculinity, possession of money, political power, key to inheritance, sex as good Christianity/religiosity in the ability to abstain, sex as tradition in ability to conform to cultural activities, and other manifestations of sex, all make for a potent force. And yet school students, particularly females, despite their theoretical knowledge, do not seem to be well versed in, nor do they have the means to, protect themselves from these forces and diseases. Their socialisation has not begun to adequately address these forces.

In the case of HIV then, from the cultural perspectives given in Chapter Five and Six alone, one would also predict that the battle to contain HIV/AIDS would be waged on all the fronts involved: political power, sex, gender, economy, culture and education. Single-issue anti-HIV/AIDS awareness strategies, largely donor driven via international economic and cultural value considerations, while playing an important role, increase the separation of Malawians into the traditional poor and modern elites. And while the

³⁹¹ Between January and May 2002, despite the most severe famine since 1949 (Cf. Vaughan, 1985), the premier subject of political discourse in Malawi was the issue of the 'Third Term'. The 'Third Term' question was whether the constitution should be altered to enable President Muluzi to stand for another term. This issue, as in Namibia, Zambia and Zimbabwe, is related to the issue of resource accumulation by ruling elites while in power. These accumulated resources are, in the context of a small economy with a culture of wealth extraction rather than creation, jeopardized by relinquishing power. These *zosiilana* (inheritance) debates consume a disproportionate amount of intellectual and creative energy and reflect the seizure of goods from recently widowed females once the power of the man to protect them is removed. On the national stage incomers - instead of creating new wealth - covet and seek to seize wealth from the previous rulers. It is argued here that a satisfactory 'retirement scheme' for former rulers and their principal allies would alleviate this problem, as would a culture of sustainable wealth creation. It is further argued that until the political impediments represented by the 'Third Term' debates are solved health will always trail far behind the priority list - and the traditionalising political dynamic will flourish.

western anti-HIV/AIDS strategy is increasingly 're-colonised' (Fredland, 1998: 566) by western donor agencies, there is, as we have pointed out in Chapter Five, a traditional response and restoration attempting to deal with the consequences of HIV/AIDS.

This is a trend that mirrors the cultural battles we noted between colonial western medicine and culture and indigenous cultures in Chapter Two. The 're-colonisation' of anti-HIV/AIDS strategies also unfortunately extends to gender issues where elite Malawian and western feminists and gender empowerment workers sometimes dogmatically assume that cultural change can be imposed on African women without the prerequisite accompanying socio-economic changes. It is argued that female student socialisation has yet to address the power of the dominant male oral sphere, a sphere that, with its misogynous, antifeminist and traditionalist messages. For example many of the gender seminars on HIV/AIDS have ignored the large amount of misogynous and overtly anti-feminist discourse and rhetoric in large chunks of Malawi and Southern African popular music. This rhetorics and discourses are fed into the oral public sphere where they easily dilute seminar or text derived discourses (Lwanda, 2001).

And scholars who, in the context of HIV/AIDS, identify the sources of economic and sexual disadvantages of female students, in relation to males, (Cf. Munthali, 2000; Chimbwete, 2001) as lying in educational disadvantage suggest that improvements in female education will erode this disadvantage. But in only emphasising western formal education, these workers may miss a crucial ingredient. Chimbwete (2001: 250) himself noted that:

Life skills are defined by WHO as 'abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life'. Life skills are a combination of skills in decision-making and problem solving; creative and critical thinking; communication and inter-personal relations; self-awareness, and coping with emotions and causes of stress (WHO/UNFPA/UNICEF, 1999)...

The major criticism of the current education in Malawi is that it only focuses on facts and examination performance (World Bank, 1995). The current education system does not adequately equip young people for life after school and is partly responsible for the poor employment situation in Malawi.

But these life skills are not useful if they are not married to the socio-economic environment. When educationists are seeing many of their own students' students dying of HIV/AIDS before finishing school, placing sole or major hope on a strategy that is in crisis is questionable; these students are not dying of ignorance about HIV/AIDS, as we saw in Chapter Five. And there are some children still not able to attend school. This point is crucial to the suggestion in this work that a direct attempt by western medicine/health promotion concepts at engaging directly with the village culture to involve the majority of those who do not benefit from prolonged western education and are thus educated by traditional culture may, in the short to medium term, be more appropriate in the case of HIV/AIDS prevention. The teaching of these life-skills should not be limited to school attendees. School dropouts and those who have never attended school should be included. *Anankungwi* and other village female culture brokers should be persuaded to include appropriate HIV/AIDS prevention strategies in their socialisation processes.³⁹²

Munthali (2000: 365 – 369), as an educationist, takes a rather too optimistic outlook on the redemptive qualities of top-down education on rural communities but is more realistic about the failure to address local 'conditions, especially issues concerning cultural practices (2000: 366)'. However her confidence in donors and central government is misplaced in view of the intense competition for resources between education for all (EFA) and the needs of elite children.³⁹³ The Kamuzu Academy, an institution that is estimated to consume up to 40% of all money spent on secondary education each year, is an example of the unbalanced needs of the elites (Cf. Kandoole and Phiri, K., 1989: 54 – 55 and 61 – 64). In Malawi it encapsulates all that is wrong with the education paradigm in the battle against HIV/AIDS: having consumed a large chunk of available education money over the last seventeen years, it has yet to be shown – and there is evidence to the contrary - that its graduates are any less likely to fall victim to HIV/AIDS.

³⁹² For example: the use of protective gloves or adequate care in nursing HIV patients, safe non-penetrative sexual practices if the HIV status is unknown, and the emphasising sexual taboos preventive of HIV/AIDS.

³⁹³ According to Munthali, the Department for International Development in UK sees the role of the international community as promoting 'the centrality of education for development, and to help individual countries to define strategies to give priority and sustained investment to primary education for all (2000: 369)'.

We have noted that education in Malawi hybridises Malawians during their schooling phase; but that many of them revert to a largely traditional culture because of their exclusion from the westernised form of lifestyles which their education equips them for because of economic reasons. We also noted that HIV/AIDS discourses are largely in English and are aimed at lifestyles only affordable in Malawi by elites. Further we noted that one of the most potent mediums of communication in Malawi is the oral public sphere. Thus by using English texts meant for the elite and by aiming these at the literate sector HIV/AIDS messages fail to reach the majority. WE also noted that as they are avid consumers of the oral public sphere, especially the music, school going students may be influenced by the messages, ambiguous or otherwise deposited here.

In the health sector, localised interventions can improve communal health drastically. For example, Schroeder et al (2001: 1209 –1212) showed that, in children under 5, good houses improved health in Malawi. But, how sustainable is an intervention like this, which includes the introduction of items requiring future repairs like iron sheets? Interventions can only be sustainable if they will benefit from communal acceptance, if only to bypass the *ufiti* engendering effect of selectivity. Interventions will also succeed if they are respectful of local traditions and seek ways of weaving themselves innovatively around the recipient.

Finally, we may postulate therefore that, from this multi-disciplinary study, to institute effective youth health promotion measures against HIV/AIDS a number of steps are necessary: firstly, acknowledging the socio-cultural and economic context of Malawi; secondly instituting a reappraisal of successes and achievements to date; and finally a more culturally engaged pragmatic framework for action.

Acknowledging the prevailing context.

This context is constituted by the political, economic, cultural, medical and educational systems and resources available in Malawi. Only by a realist acknowledgement of the available resources can a sustainable programme be fashioned.

Political

- First, it is especially necessary to take note of and acknowledge, from a realist and proud stance, the socio-economic and cultural reality of life in Malawi.
- Recognise that, in the fragile postcolony, the dominant role of accumulative hegemonic politics should never be minimised when it comes to the ability or otherwise to fight disease; politicians dispose of national resources.³⁹⁴ Amartya Sen's (1983) theories on 'entitlements and deprivation' apply well to Malawi as the current (2001 – 2002) famine - with its causes in issues of entitlements, allocations, distribution, food security, social justice and governance – demonstrates. Considerations of the role governance plays in resource allocation are crucial in HIV/AIDS prevention. No postcolonial government has accorded HIV/AIDS the major priority it deserves. Where action has been taken, it has been motivated by the self-interest and short-term considerations of the elite.

Cultural

- Recognise that in Malawi the social security system is provided by the extended family system, the community and other informal activities. These social systems may be allied to a number of cultural practices and taboos. HIV/AIDS prevention strategies need to intervene without destroying these systems. But HIV/AIDS discourses should also exploit these systems where this is practical.

Economic

- It is necessary to take cognisance of the important role of poverty in HIV/AIDS spread. In Zomba, proto-elite, but poor, university students may be torn between theoretical science and the reality of village life and its malaria-inducing mosquitoes or its 'abstinence' preaching adults.

³⁹⁴ As well as noting the role that politics plays in socialising school attending students' attitudes to concepts of nation, region, community, self, power, wealth, value of life, issues of gender, class and ethnic cleavages.

Medical

- Recognition of the crucial position of traditional practitioners would bring their work within the legal framework of Malawi. Nearly forty years after independence, the relationship between the state and traditional practitioners is still informal, with registration of practitioners merely regulated by, effectively, voluntary guidelines. The Medical Practitioners and Dentists Act of 1987 does not prohibit the practice of ‘any African system of medicine’ provided the practice is safe. The current registration system is not accompanied by validation procedures. A system that strengthens peer review and validation of traditional practitioners is required. As well as facilitating the transmission of positive HIV/AIDS discourses into the practitioners’ medical sphere it will facilitate the re-negotiation with these practitioners of ways to abandon hazardous practices.

Educational

- The recognition that the educational system as presently configured only succeeds in training a lucky minority to pass examinations and become part of the elite. The Malawi educational system does not adequately equip students with the critical life-skills its syllabus intends it to. This lack of critical life-skills exposes these students to ‘misconceptions’ and ambiguities when it comes to assimilating HIV/AIDS messages.

Re-appraisal of what has been achieved so far

Despite the many political, social and economic constraints noted in this work, some progress has been made in the battle against HIV/AIDS. There is however a need to reappraise past and current achievements against expected resources and the failures experienced so far.

These appraisals need to be more pragmatic and should eschew the ‘donor-driven’

methodologies that place imported paradigms above locally derived and validated knowledges.

Educational and Political

- The recognition of the paralysing role of a 'high information and low resources status', for example is called for. Many agencies have concentrated on providing information without providing resources or strategies to enable behaviour change. A national youth policy that includes appropriate HIV/AIDS prevention and containment measures and the harnessing of the minimal resources available in helping prevention is required.

Cultural

- This reappraisal should include a historical approach to avoid repeating earlier mistakes. It is worth noting that the HIV prevalence rate among the 5 – 14 age group, part of my target study group, is, at about 2.2% (MNACP, 1999), around the same level as that originally found among ante-natal patients in 1985. If the cycle of replication of the epidemic from its localised bases is repeated (as with ante-natal patients) among this group in 2020 the prevalence rate will have risen to 30%.
- A stronger recognition of the de/humanising aspects of HIV/AIDS is called for in educational syllabi. We noted that, in the wake of HIV/AIDS, there had been a resurgence of the traditional culture of care – for those suffering from disease - in the community. But we also noted that the belief, among students and the population at large, that the value of rural life was cheap has gained wider currency for two reasons: the misery of many in life, illness and death and the large class/wealth disparity in Malawi. To motivate students in revaluing life even in constrained circumstances the care of the suffering and sick requires to be improved. For example, the use of appropriate effective and available traditional herbal analgesics - rather than watch people suffer - would be a

positive step.³⁹⁵ The images of suffering and misery are important in socialising students in 'quality and value' of life concepts. A stronger emphasis on value of life discourses is called for.

Need for a more culturally engaged and pragmatic framework for action

It is not possible to change the socio-economic base of Malawi in the short-term, but this thesis has identified medical, cultural, educational and political factors that can be changed if the socialisation of students in the light of HIV/AIDS is to be improved.

Medical

- A formal epistemological dialogue between western medicine and traditional medicine is long overdue, and would be a good starting point. This, by underestimating the importance of traditional medicine to Malawians, has been one of the failures of the HIV/AIDS strategy in Malawi. A western medical explanation of the infective or epidemic aspect to the traditional culture practitioners may be possible and is necessary. But a pre-condition would be the understanding that in some of their residual practices lay residual communal gender, hierarchical power roles, age old cosmological beliefs and practices that maintain order.

Cultural

- An engagement with localised practices should use the same methods of harm reduction that were utilised with cultural sub-groups in the west. In suggesting an engagement with traditional culture it is here suggested that this should be a positive one. A positive engagement with indigenous practices is one that recognises that while one could or could not, in the short-term, completely change customs promotive of HIV/AIDS, one could make them safe. There is a

³⁹⁵ In February 2002, for example, the use of cannabinoids (used by some traditional practitioners, but illegal, in Malawi) in multiple sclerosis in the UK is under consideration. HIV/AIDS causes similar, and more severe, pain, debility, nausea and misery.

precedent for this suggestion. It has been done in the West for homosexuals. Homosexuals were not made to give up their sexual orientations; they were, although most could afford it, provided with information and resources - like condoms - to enable 'safe sex'.

- Each localised practice should be tackled separately. For example: If a *fisi* is to act as a surrogate 'husband' to a woman whose own husband is infertile, he should be HIV tested first. The practice would continue at reduced HIV risk.³⁹⁶
- Similar concepts for initiation *afisi* and the other high-risk cultural practices like *chokolo* and cleansing rites should be utilised. The training of *anankungwi* to give safe contraception advice and empowering them to omit those aspects of the initiation ceremonies that are hazardous to female health could be a major advance. This is more likely to succeed if it was done without diluting their role in society (Cf. Wamui, 2001).
- The 'reformation' of cultural practices should be attempted without affecting their cohesive role in village or locality cultural power dynamics.

Given the unlikelihood of rapid socio-economic change, this, if attempted using positive dialogue between western medicine and traditional culture, could be the most significant advance in arresting rural HIV/AIDS.

Tembo et al's (1993: 43 – 48) solution of 're-socialisation programmes for adults, elders, sex educators (*anankungwi*) and village headmen in rural villages' can only be successful if the socio-economic environment changes or if the 're-socialisation' takes into account the socio-economic realities. Rather we suggest a *re-negotiation* with these groups to tease out the harmful practices in localities without disturbing the main cultural constructs that, as we have suggested, largely build and maintain communal order and behaviour. When empowered in this manner traditional practitioners, like TBAs, have shown themselves capable of delivering a western medical agenda, without losing their other *anankungwi* roles and functions. Even the World Health Organisation has recognised the importance and relevance of traditional medicine if it is made

³⁹⁶ Cf. western medicine's surrogacy methods.

Education

- The dynamic between culture, medicine, politics and the socio-economic environment manifesting as traditionality should be engaged and exploited in HIV/AIDS discourse as it relates to Malawian school students. As we have noted in this thesis, their education produces mostly dualised and hybridised Malawians. The former, who form the majority, while predominantly traditional are able – when circumstances demand - to switch to a more westernised mode, for example at work or sometimes in accessing medical help. The hybrids show a more critical appreciation of the difference between western and traditional culture. Both groups are however influenced, and sometimes constrained, in their choices by the availability or otherwise of their chosen form of medicine. Inevitably it is western medicine that tends to be scarce. HIV/AIDS discourse should therefore be more appropriately situated in these dual and hybrid cultures' public spaces to maximise the impact of Health Prevention messages.
- The adoption of a pro-active dialogue in order to positively influence emerging socialisation models is called for. A response to the HIV epidemic from African traditional medicine should have been expected. The HIV epidemic has now lasted a generation. We would contend that this is long enough for traditional cultures to have begun formulating their responses. However, some of the 'localised' responses that are emerging - like 'advocating sex with virgins or under-age girls - are from the moral and western medical viewpoint clearly pathological, and need to be dislodged before they become firmly - and locally - embedded. They are examples of the exploitation and corruption of culture by the powerful. These powerful exploiters are found in themes like *chidyamakanda* (sugar daddies who seduce young girls) and in *ufiti* discourse.
- The equipping of students with better safe-sex messages and practices.
- These positive engagements should be sited at crucial points in the socialisation of male and female students with respect to their sexual health. These engagements should use realistic rhetoric and discourse, placed in the most

accessible public sphere, as well as sustainable methods and materials appropriate to national resources, to make the anti-HIV/AIDS battle more realistic rather than aspirational.

Political

- All the foregoing requires considerable political will and leadership. Without this anti-HIV/AIDS messages and efforts will remain fragmented and will miss a significant part of the population.

This thesis suggests an engagement with these localised practices to institute ways of making them effective from an HIV/AIDS prevention and containment point of view, partly through interventions in aspects of students' socialisation. The fact that Malawi is poor does not, on its own, preclude effective HIV/AIDS prevention. But the limited resources dictate that the other factors in the equation, like politics and culture, become even more important.

Rural Malawi, and its localised cultural contexts, deals with the contradictions between modernity, resources, political power, other imperatives and the tragedy of HIV/AIDS via the mechanism of traditionality. In the concept of traditionality we see localised communities coping with new illnesses using a mixture of traditional experience and limited western resources. As Baker's (1975) and King and King's (1992) accounts of western medicine confirm, it was nearly always thus: a majority service for whites and the African elite and the rest for the rest.

But in the colonial, first postcolonial and second postcolonial periods *anthu wamba* (the peasantry) Malawians have demonstrated a resourceful creativity in responding to tangential or significant adversity through traditionality. Traditionality preserves localised appropriate traditions through a process that responds to western ontological (as opposed to cultural) modernity by a process of 'cultural blending and creative assembly of diverse traditions' (Grinker et al., 1997: xxii). This interface and intercourse with modernity is, at a cultural level, leveraged in indigenous culture's

favour because – at that interface – indigenous culture is more proactive and sustainable where western culture is prescriptive and even more susceptible to economic forces.³⁹⁷

The concept of traditionality is in line with Kroeber and Parson's (Kuper, 1999: 69) definition of culture as 'transmitted and created content and patterns of values, ideas, and other symbolic-meaningful systems as factors in shaping of human behaviour and the artefacts produced through behaviour'. In relation to HIV/AIDS, traditionality is recruited by the elite and the poor alike in spreading the burden of HIV/AIDS. In Malawi poor people shoulder a bigger burden than the rich (Cf. Mtika, 2001). Newman's earlier concept (ibid: 38), despite its deficiencies, of culture as 'that which makes life worth living' resonates with the school students discourses of fatalism, boredom, choices, behaviour and resources. It also resonates with *moyo wa masiku ano* (today's life or mores). A life of aspiration to an impossible goal is probably not worth living and positive contextual socialisation needs to address this factor.

This thesis has demonstrated that the educational system in Malawi produces a number of categories of Malawians: those who leave education early remain largely in the traditional side of Malawi's dual (western/traditional) culture; those that succeed to secondary and tertiary levels become hybridised to different extents; and finally the minority that attain tertiary education or other forms of employment (with inbuilt social mobility) may attain various levels of both critical and uncritical hybridisation and westernisation. We showed that this process of hybridisation and westernisation is dependent on socio-economic circumstances, with traditional socialisation at home, and through various discourses oral and musical, playing a large role. In the Malawi setting this hybridisation would ideally be a critical one that enables students to view and experience HIV/AIDS in the realistic socio-economic settings in which they exist. But it has also been demonstrated that, with reference to HIV/AIDS, the processes of education, prevention, treatment and care will all depend on available social, economic, medical circumstances, as well as on the achieved degrees of critical education. The discourses engaged in and influencing each group, in relation to HIV/AIDS, will thus tend to be influenced largely by inputs from traditional and western culture which exists

³⁹⁷ Cf. the debate about Zambia which was occasioned by Ferguson's book *Expectations of modernity* by Nyamnjoh (2001: 362 – 369) and Sichone (2001: 369 – 379).

in Malawi's oral public sphere where the dangers of ambiguity and 'misconceptions' are high. The effects of education on students' perceptions and ability to prevent HIV/AIDS has to be critically looked at in a nation where students may lead hybridised lives at schools and colleges but revert, for socio-economic reasons, to dualised existencies (largely traditional) in their interaction with medical, political and social services. An appropriate Malawi educational system would enable students, whether hybridised, westernised or more traditional to critically appraise HIV/AIDS discourses and find solutions appropriate to their circumstances.

The implementation of any resulting policies will require tackling some of the main challenges: political will; the cooperation or otherwise of culture brokers; a re-appraisal of the educational system of Malawi; and a more realistic recognition by western medicine in Malawi of its, as yet, limited ability and restricted reach.

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Appendix 1

Tikutha by Dennis Phiri

(Quoted with oral permission from the Copyright Society of Malawi).

Tikutha! Tikutha anthu! (We are perishing, people we are perishing!)

Ine chomwe ndaona (What I have seen is this,

Satana wamanga masiku, (Satan is now in charge)

kulamulira aliyense; (controlling everyone.)

zibale ziti zipita? (which relative will go next?)

Maliro ndi akale (Death has always been with us)

koma lero zanyanya (but now things are too much!)

Tawafunsemi agogowa (Ask grandmother)

momwe zimakhala kale. (how things were in the old days.)

Magulu onse a wanthu (All groups of people)

alowelera inu (are engaged in this process,)

sitikuopa kuti kunjaku zinthu zabeba (not fearing that out there things are bad.)

Imvani anthu kusewera ndi moto (See people playing with fire,)

ungadzioche chabe (you will merely burn yourself.)

Chala mkamwa mwa njoka (Sticking a finger in a snake's mouth)

ndikudziputa dala. (is asking for it)

Refrain:

Tikutha! Tikutha anthu! (We are perishing, people we are perishing!)

Taganizani inu ku mortuary (Imagine at the mortuary)

kusowa koponda inu, (you cannot find a space to step on,)

abale athu ngunda ngunda ngati achitira dala (your relatives lying there scattered on the floor as if play acting.)

Mabokosi kale lija amatiopsya zedi, (Coffins used to scare us stiff in the old days,)

lero siawaagulitsidwa pali ponse wawa. (now they are sold everywhere.)

Sementi nawo lekeleni kuti idure lero (And cement is so expensive nowadays,)

kumanganyumba nditsiriza nchitoyi yakula? (will I finish building the house, it is a big job?)

Tikutha! tikutha anthu! (We are perishing, people we are perishing!)

Likanakhala dzana lija (If it was the old days)

nsembe ikanathiridwa (sacrifices would have been made)

yochotsera zowawazi tipumuleko wawa (to remove these bitter problems so we can rest.)

Koma lero mizimu yatitembenukira. (But today the ancestral spirits have turned against us.)

Refrain...

Musafunse za chifukwa machimo achuluka. (Don't ask why - there is too much sin.)

Kadzayesenu tsiku lina mudzayende ku Lilongwe (Try one day walking around Lilongwe)

kuKabula kumahotela awa mudzawaona (and Blantyre hotels you will see them)

anamwali anu ali mbwanda mbwanda kuonetsatu (your maidens spread-eagled indecently showing)

kuti infa alibe nayo mantha. (that they do not fear death!)

Refrain: Tikutha tikutha anthu!

Kubvuta kwache nchitoizi (The problem is that these deeds)

zimakonda kumdima, (prefer the dark,)

aliyense osafuna kuti adziwe inu (no one to recognise you.)

Mukadwala adzimvetsa anzanu (But when you fall ill your friends hear you)

amakayikilira makolo akale akazi anu; (blaming your ancestors, your wife...)

kudandaula kunamiza anzanu (you complain, deceiving your friends,)

anadilodza ine, (I was bewitched;)

mwaiwala nchito zanu zakumdima dzana. (forgetting your nocturnal activities of yester year.)

Kubvutitsa anthu kugulitsa katundu (You impoverish your people selling belongings)

kuti mupeze moyo; (so that you can extend your life;)

ukazioche wanu uja lero onse balala (your bravery now evaporated.)

Refrain: Tikutha!

Koma Satana walumpho mulomo, (But Satan has gone beyond words,)

kugwirapo nchito inu (he has worked hard,)

khutu mwapa nzeru zapha latsala ndi thupi lokha (killing the ears, killing the brain, only the body remains.)

Mukanadziwa kuti mutauni ndimkachere (Had you known the dangers of the town)

mukanasintha ndalama zanu kumanja andabale. (you would have invested in better pursuits.)

Oipa aja amzembera, (The bad company abandon him,)

lero siwo apuma. (today he goes to his rest.)

Katundu watha kugulitsa kufuna moyo (His inheritance exhausted in the quest for life;)

makolo kulira mkazi kulira (parents weep, the wife weeps)

ndi ana omwe kulira (and even the children weep.)

Nchito zonse panyumba pano zafa lero bambo. (All is dead in this household father)

Appendix 2

Sources consulted

Archival sources of data searched included:

- The University of Edinburgh Library, including its Centre of African Studies Malawi collection. A good source for the colonial and early postcolonial phase, but not on the period after 1986.
- The New College Library has some post 1986 material and the PhD theses are easier to access.
- The University of Glasgow Library.
- The Malawi National Archives, though badly dilapidated and neglected, has a dedicated staff doing their best under the limited resources. I found that little cultural, political and medical information pertaining to the post 1961 period exists in the Archives. Some requests can never be found, the material appears to have disappeared. For example, two of the 'HKB' (Dr Banda) papers I wanted had been removed from the archives.
- The Centre for Social Research, Zomba, has a lot of useful material on HIV/AIDS and the University of Malawi's research output.
- Individual Ministry, Hospital, and institutional libraries.
- Interviewing informants.
- The University of Malawi Chancellor College Library's Malawiana section was the most useful for my period post 1961 social science data searches. The Library, with all its shortcomings, has an impressive Malawiana collection. The doctoral and master theses collection is very useful but not complete.
- The Malawi College of Medicine, the Kamuzu College of Nursing and the Lilongwe School of Health Sciences Libraries.
- The Library of the Royal College of Physicians was able to access all material I requested with the 'search string' 'Africa, Malawi, culture, medicine, tradition, history' from its own and archives and those of the British National Library for me.
- The Scottish National Library was consulted for its colonial material.

- Other Libraries with significant Southern African studies material, such as Cambridge University, Stirling University and Leeds University were visited and consulted.
- Computer searches of social science databases on the Internet were undertaken.
- Books by missionary or expatriate workers. Some of these contain valuable insights into traditional patterns of the early colonial period.
- Contemporary records including journals, newspapers, pictures, videos, music and other oral recordings were consulted.

Appendix 3

QUANTITATIVE Quantitative Questionnaire (J Lwanda: Medicine)

Thank you for agreeing and sparing the time to see me. I am studying various aspects of medicine. It is for this reason that I need to elicit your views. There are no right or wrong answers. I am only interested in your views.

Zikomo pobvomera kuti ndilankhule nanu. Ine ndikufufuzafufuza zinthu zingapo zokhudzana ndi matenda, mankhwala ndi mwambo. Sikuti pali mayankho ofunika, iyai, ine ndikufuna kuti ndidziwe maganizo ainuyo.

Sikomo kweijinji pakum'mba lipesya kunguluka nawo, kum'mba nganisyo zyawo, kwausya ya mtela ni ndamo zyakunokuno. Akadandaula kuti mwine chalemwisye kadyanje kakwe, bola kum'mba nganisyo zyawo.

- 1 Rheumatism (Nyamakazi)
- a) Are you aware of Rheumatism (nyamakazi)?

YesNo
- a) Ana nyamakazi akusadyimanyililaga?

EehIyayi
- a) Kodi mumadziwa kuti nyamakazi ndi chiani?

IndeIyai?
- b) Do you happen to know what causes it?

YesNo
- b) Ana achimanyi chichikusatandisyaga?

EehIyayi
- b) Chimene chimayambitsa nyamakazi mukuchidziwa?

EehIyai
- c) If yes, what?
- c) Naga akuchimanyilila, chichi, atusalile.
- c) Ngati mukuchidziwa, ndi chiani?
- d) Do you know how it can be prevented?

YesNo
- d) Ana kalewe kakwe akamanyi?

EehIyayi
- d) Kodi mukudziwa kapewedwe kache?

EehIyai
- e) If yes, how? i) Hospital medicine?
- ii) Traditional medicine?
- iii) Other?
- e) Kapewedwe kache nkotani? (i) mankhwala amchipatala?
- (ii) mankhwala a asinganga akumudzi?
- (iii) Zina, ziti?
- e) Naga akamanyi, kujilewaga chamtuli?
- i) Kuchipatala
- ii) Mtela waisamba
- iii) Pana kalewe kane
- f) Are you aware of how it can be treated?

YesNo
- f) Ani kuposya kwake akumanyi?

EehIyayi
- f) Kodi mukudziwa machiritsidwe ache?

EehIyai
- g) If yes, how?
- g) Ngati mukudziwa, amachiiritsa bwanji?
- g) Akusaposityaga uli?.....
- h) Can nyamakazi be cured?

YesNo
- h) Nyamakazi ingachiritsidwe mpakana kupolelatu?

EehIyai
- h) Ani komboleka nyamakazi kumala/kupola?

EehIyayi
- i) If yes, how can it be cured?
- i) Izi zingatheke/ingapoletsedwe bwanji?
- i) Jikusamalaga ni chi?
- j) If you had nyamakazi who would treat you?
- 1) Sing'anga?2) Hospital?3) Either?
- j) Kodi mutakhala ndi nyamakazi mukhoza kukafuna mankhwala kwa ndani?
- 1) Kwa a sing'anga2) Kuchipatala3) Konse konse

- j) Jili jakamwilemo, mpaka ajaule kwapi kuti jimala?
- | | | |
|--|----------------|-----------|
| 1) Kwa a sing'anga | 2) Kuchipatala | 3) Kosope |
| k) Can the Sing'anga cure nyamakazi? | Yes | No |
| k) Kodi asing'anga angapoletse nyamakazi | Eeh | Iyai |
| k) Ani asin'ganga komboleka kumalalisya/kupolesya nyamakazi? | Eeh | Iyayi |
- 2 a) Are you aware of Malaria (Malungo) Yes No
- a) Kodi ntenda ya malungo mukuidziwa? Eeh Iyai
- a) Ana malungo agamanyi? Eeh Iyayi
- b) Do you happen to know what causes it? Yes No
- b) Kodi chimayambitsa malungo mukuchidziwa? Eeh Iyai
- b) Ana achimanyi chichikusatandisyaga? Eeh Iyayi
- c) If yes, what?
- c) Ngati mukuchidziwa ndi chiani?
- c) Naga akuchimanyilila, chichi, atusalile
- d) Do you know how it can be prevented? Yes No
- d) Kodi kupewetsa malungo mukukudziwa? Eeh Iyai
- d) Ana kalewe kakwe akamanyi? Eeh Iyayi
- e) If yes, how?
- i) Using hospital medicine? ii) Using traditional medicine? iii) Other?
- e) Malungo ungawapewetse bwanji? i) Mankhwala achizungu?
- ii) Mankhwala achimidzi? iii) Zina?
- e) Malungo kugalewaga chamtuli? i) Mtela wakuchipatala ii) Mtela waisamba iii) Pana kalewe kane
- f) Are you aware of how it can be treated? Yes No
- i) Hospital medicine ii) Traditional medicine iii) other?
- f) Ndiye malungo amawachiritsa bwanji? i) mankhwala akuchipatal?
- ii) Mankhwala akumudzi? iii) Mwina mwache?
- f) Ani kuposya kwake akumanyi? Eeh Iyayi
- f) Akusaposyaga uli?
- i) Mtela wakuchipatala ii) Mtela waisamba iii) Pana kalewe kane
- h) Can malaria be cured? Yes No
- h) Pali mankhwala amene angachiritsire munthu wodwala malungo ndi kumusiitsa kuti asadzadwalenso malungo? Eeh Iyai
- h) Ani komboleka malungo kumala/kupola? Eeh Iyayi
- i) If yes, how can it be cured?.....
- i) Ngati mwabvomera, izi zingatheke bwanji?
- i) Gakusamalaga uli?
- j) If you had malaria who would treat you?
- i) Sin'ganga ii) Hospital iii) Either
- j) Inu mutadwala malungo angakuchiritseni ndani?
- i) Sin'ganga ii) Kuchipatala iii) Konse konse
- j) Gali gakamwile malungo, mpaka ajaule kwapi kuti gamale?
- i) Kwa a sing'anga ii) Kuchipatala
- | | | |
|---|-----|-------|
| k) Can sin'ganga cure Malaria? | Yes | No |
| k) Kodi asing'anga angachiritse malungo? | Eeh | Iyai |
| k) Ana komboleka asin'ganga akumusi/achikuda kuposya malungo? | Eeh | Iyayi |
- 3 a) Have you ever heard of fortification (kukhwima)? Yes No
- a) Kodi zakukhwima munazimvapo? Eeh Iyai
- a) Ana pakwete papikenepo yakukomala? Eeh Iyayi
- b) Do you happen to know how it is done? Yes No
- b) Kodi mukudziwa m'mene anthu amakwimira? Eeh Iyai
- b) Ani akusamanyilila yakusatenda wandu kuti akomale? Eeh Iyai
- c) What would you use it for?
- c) Chitumikiro cha kukhwima ndi chiani?
- c) Masengo gakukomala ni chichi?

d) Do you think it works	Yes	No
d) Kodi kukhwimaku kumathandiza?	Eeh	Iyai
d) Ana komalako kukusakamulaga masengo?	Eeh	Iyayi
e) If yes, how did you know?		
e) Apa munadziwa bwanji?		
e) Waimanyi chamtuli kuti ikusakamula masengo?		
f) Are you aware of how it can be undone?	Yes	No
f) Mukudziwa m'mene kukhwima kungatetsedwe?	Eeh	Iyai
f) Ani komalaji ikusakomboleka kupitikuzya?	Eeh	Iyayi
g) Would you think of using this yourself?	Yes	No
g) Inuyo mungafune kuti mukwime?	Eeh	Iyai
g) Walakwe komboleka kuganisa kuti akomale?	Eeh	Iyayi
h) If yes, who would provide this service for you?		
i) Sing'anga ii) Hospital iii) Other		
h) Angakukwimitseni ndi ndani?		
i) ASing'anga ii) Kuchipatala iii) Ena		
h) Ali asachile kukomalako, mtela wakwe mpaka aupate kwapi?		
i) Kwa aSing'anga ii) Kuchipatala iii) Kwine		

4

HIV/AIDS

a) Are you aware of HIV/AIDS	Yes	No
a) Kodi inu mukudziwa za Edzi?	Eeh	Iyai
a) Ana Edzi, kaliwondewonde ajimanyi?	Eeh	Iyayi
b) Do you happen to know what causes it?	Yes	No
b Mukudziwa chimene chimayambitsa Edzi?	Eeh	Iyai
b) Ana achimanyi chichikusatandisyaga?	Eeh	Iyayi
c) If yes, what?		
c) Ngati mukudziwa, chimayambitsa Edzi ndi chiani?		
c) Naga akuchimanyilila, chichi, atusalire		
d) Do you think that it can be prevented?	Yes	No
d) Kodi Edzi ingapewedwe?	Eeh	Iyai
d) Ani akupela kuti Edzi, kaliwondewonde jikomboleche kujilewa?	Eeh	Iyayi
e) If yes, how can it be prevented?		
e) Edzi ingapewedwe bwanji?		
e) Mundu Edziji, kaliwondewonde, mpaka ajilewe chamtuli?		
f) Do you believe that it can be treated?	Yes	No
f) Mukukhulupirira kuti Edzi ingachiritsidwe?	Eeh	Iyai
f) Ana akusapililaga kuti komboleka kuposya Edzi, kaliwondewonde?	Eeh	Iyayi
g) If yes, how can it be treated?		
g) Ngati mwavomera ingachiritsidwe bwanji?		
g) Naga eeh, mpaka ajiposye chamtuli?		
h) In your opinion is there a cure for HIV/AIDS?	Yes	No
h) Inu mukuganiza kuti pali mankhwala ochiritsa		

Edzi?	Eeh	Iyai	
h) Munganisyo syawo, ana pana mtela wa			
Edzi, kaliwondewonde?	Yes	No	
i) If yes, do you think that it can be cured?	Yes	No	
i) Mukuganiza kuti Edzi ingachiritsidwe, mpaka			
mpakana munthu kuchiriratu osadwalanso?	Eeh	Iyai	
i) Ana akupela komboleka Edzi kumala ?	Eeh	Iyai	
j) In your opinion, who is best placed to treat HIV/AIDS?			
i) <i>Singanga</i>	ii) Hospital	ii) Either	
j) Kodi amene angachiritse Edzi kwenikweni ndi ndani?			
j) Ana achipatala ni a sin'ganga, akupela wampaka			
aposye Edzi m'nope ni wa?			
i) Sing'anga	ii) Chipatala	iii) Wosope	
k) In your opinion who can cure HIV/AIDS			
i) <i>Singanga</i>	ii) <i>Hospital</i>	iii) <i>Either</i>	iv) <i>Neither</i>
k) Kodi amene angachiritse, mpaka kuithetsa, Edzi ndi ndani?			
i) Sin'ganga	ii) Chipatala	iii) Onse	iv) Palibe

5 *Kulodza/Ufiti (witchcraft)*

a) Are you aware of/ever heard of <i>ufiti/kulodza</i> ?	Yes	No
a) Kodi munamvapo zaufiti?	Eeh	Iyai
a) Ana usawi aumanyi?	Eeh	Iyayi
b) Do you happen to know who does it?	Yes	No
b) Kodi mukudziwa kuti amachita ufiti ndi ndani?	Eeh	Iyai
b) Ana awamanyi wakusatenda usawi?	Eeh	Iyai
c) If yes, what for?		
c) Ngati mwavomera, ufitiwo amachitira chiani?		
c) Naga awamanyi, akusatenda usawi ligongo chichi?		
d) Do you know how it is done?	Yes	No
d) Mukudziwa m'mene amachitira ufitiwo?	Eeh	Iyai
d) Ana akumanyilila katende kakwe?	Eeh	Iyayi
e) If yes, how?		
e) Amapanga bwanji?		
e) Usawiwo akusatenda chamtuli?		
f) Are you aware of how it can be avoided?	Yes	No
f) Mukudziwa m'mene mungapewere ufiti?	Eeh	Iyai
f) Ana kalewe kake akamanyi?	Eeh	Iyayi

- g) If yes, how?
- g) Mungaupewe ufiti bwanji?
- g) Naga akamanyi, kuulewaga chamtuli?
- h) If you were a victim of *mfiti* who would treat you?
- i) *Singanga* ii) Hospital ii) Either
- h) Atakulodzani angakuchiritseni ndani?
- i) Sin'ganga ii) Ku chipatala iii) Konse
- h) Ali walogile, mpaka akapate kwapi chitandizo?
- i) Kwa a sin'ganga ii) Kuchipatala iii) Kosope
- i) Do you think *ufiti* works? Yes No
- i) Inuyo mukuganiza kuti ufiti umagwira nchito? Eeh Iyai
- i) Ana akupela kuti usawi ukusakumulaga masengo? Eeh Iyayi
- j) If yes, what makes you think that?
- j) chifukwa chiani mukuganiza kuti umagwira nchito?
- j) Ligongo chichi akusakulupililaga kuti usawi ukusakumulaga masengo?

6. Who first told you/how did you find out about traditional medicine?

- a) Self b) Parents c) Family member
- d) School peers e) Work mates f) Others

g) I have never been to one

6) Kodi anakuuzani poyamba peni peni za mankhwala achikuda ndi ndani?

- a) Ndinadziwa ndekha b) Makolo c) Abale
- d) Ana asukulu anzanga e) Anzanga kunchito f) Ena

g) Sindinayambe ndapitako ku mankhwala

6) Kuti amanyilile ya mtela wachiboyi, wasalile wani kandanda?

- a) Jika b) Achinangolo c) Achibale
- d) Achim'jangu kusukulu e) Achim'jangu kumasengo f) Wane

g) iyayi, une nganijawilepo kwa asin'ganga

7. Have you ever been to hospital? Yes No

7) Kuchipatala munayamba mwapitako? Eeh Iyai

7) Pakwete pajawile kuchipatala? Eeh Iyayi

8. If yes, who first took you there?

- a) Self b) Parents c). Family member
- d) School peers e) Work mates f) Others

g) I have never been to hospital

8) Nanga anakupititsani kuchipatala poyamba peni peni ndi ndani?

- a) Ndekha b) Makolo c) Abale

- d) Anaasukulu anzanga e) Anzanga kunchito f) Ena
- g) Kuchipatala sIndinapiteko
- 8) Wajigalile kuchipatala kandanda wani?
- a) Jika b) Achinangolo c) Achibale
- d) Achim'jangu kusukulu e) Achim'jangu kumasengo f) Wane
- g) Une nganijawilepo/nganimbite kuchipatala
- 9) Have you ever been to a traditional practitioner? Yes No
- 9) Kwa asingamga munayamba mwapitako? Eeh Iyai
- 9) Pakwete wajawile kwa asing'anga? Eeh Iyayi
- 10) When was the last time you went to a traditional practitioner?
- a) This year 2000 b) 1998 - 99 c) 1996 - 97 d) 1994 -96 e) 1991 - 94
- 10) Munapita liti?
- a) Chaka chino 2000 b) 1998 - 99 c) 1996 - 97 d) 1994 -96 e) 1991 - 94
- 10) Wajawile
- a) Chaka cha 2000 b) 1998 - 99 c) 1996 - 97 d) 1994 -96 e) 1991 - 94
- 11) If yes, who first took you there?
- a) Self b) Parents c) Family member
- d) School peers e) Work mates f) Others
- g) I have never been
- 11) Nanga anakupititsani kwa sin'ganga poyamba peni peni ndi ndani?
- a) Ndekha b) Makolo c) Abale
- d) Anaasukulu anzanga e) Anzanga kunchito f) Ena
- g) Kwa sin'ganga sindinapiteko
- 11) Wajigalile kwasin'nganga kandanda wani?
- a) Jika b) Achinangolo c) Achibale
- d) achim'jangu kusukulu e) achim'jangu kumasengo f) wane
- g) Une kwasin'nganga nganijawilepo
- 12) What, in your opinion, causes illness? (tick any that apply)
- a) Witchcraft? b) Germs c) God
- d) Other (specify)..... e) Don't know
- 12) M'mene mumaganizira inuyo chimayambitsa matenda ndi chiyani?
- a) Ufiti b) Tizirombo (majeremu) tochokera muubve c) Mulungu
- d) Zina (ziti?) e) Sindidziwa
- 12) Ana akupela ilwele ikusatandaga ligongo chi?
- a) Usawi b) Timajeremu c) M'nungu
- d) Ine (chichi?) e) Ngaimanya
- 13) Do you intend to use western medicine in future?

a. Yes definitely b. Yes probably c. May be d. Unlikely e. Never

13) Mtsogolo muno mankhwala akuchipatala mudzawa tumikira?

- a) Inde kumene b) Eeh mwina c) Kapena
d) Sindikuganiza kuti ndidzapitako e) Sindidzapitako ai

13) Msogolomu, akupela chakamulisyeje mtela wakuchipatala?

- a) Eeh kwene b) Eeh mwine c) Kapena
d) M'ngaichile e) Yangakomboleka iyai

14. Do you intend to use traditional medicine in future?

a. Yes definitely b. Yes probably c. May be d. Unlikely e. Never

14) Mtsogolo muno mankhwala akumudzi/achikuda mudzawa tumikira?

- a) Inde kumene b) Eeh mwina c) Kapena
d) Sindikuganiza kuti ndidzapitako e) Sindidzapitako ai

14) Msogolomu, akupela chakamulisyeje mtela wakuchiboyi/wakumusi?

- a) Eeh kwene b) Eeh mwine c) Kapena
d) M'ngaichile e) Yangakomboleka iyai

15) Western medicine can harm people.

a. Always b. Frequently c. Sometimes d. Rarely e. Never

15) Mankhwala achizungu amathakukuononga/kukupweteka.

a) nthawi zonse b) nthawi zambili c) nthawi zina d) kamodzi kamodzi e) zonama 15) Mtela wachipatala ukusapwetekaga wandu.

a) Ndawi zosope b) Ndawi situpile c) Ndawi sine d) Kamo kamo e) Unami

16) Traditional medicine can harm people

a) Always b) Frequently c) Sometimes d) Rarely e) Never

16) Mankhwala achikuda/akumudzi amathakukuononga/kukupweteka.

a) Nthawi zonse b) Nthawi zambili c) Nthawi zina d) Kamodzi kamodzi e) Zonama

16) Mtela wachiboyi/wakumusi ukusapwetekaga wandu.

a) Ndawi zosope b) Ndawi situpile c) Ndawi sine d) Kamo kamo e) Unami

17) Any other comments? Zilipo ndaiwala kufunsa? Ipali ine?

Zikomo.

Appendix 4

QUALITATIVE FRAMEWORK

Qualitative Questionnaire (J Lwanda: Medicine & Culture)

ENGLISH: Thank you for agreeing, and sparing the time, to see me. I am studying various aspects of medicine and culture. For this reason that I need to get your views on a number of issues.

CHEWA: Zikomo pobvomera kuti ndilankhule nanu. Ine ndikufufuzafufuza zinthu zingapo zokhudzana ndi matenda, mankhwala ndi mwambo.

YAO: Sikomo kwekujinji pakum'mba lipesa kunguluka nawo, kum'mba nganisyo zyawo, kwausya ya mtela ni ndamo zyakunokuno.

Name/dzina/lyina..... District of origin..... ethnic group

Occupation..... Age..... Class/Form/Year Religion.....

1 Are you aware of (please tick all that apply):

- a) Rheumatism (nyamakazi)?
- b) Malaria (Malungo)?
- c) HIV/AIDS (Edzi)?
- d) Fortification (Kukhwima)?
- e) Witchcraft (Ufiti/kulodza or kulodzedwa)?

1 Kodi izi mumazidziwa? (chitani tick zomwe mudziwa)

- a) Nyamakazi
- b) Malungo
- c) Edzi
- d) Kukhwima
- e) Ufiti kapena kulodza/kulodzedwa

1 Ani walakwe akusamanyililaga: (atende tick yakuimanyila)

- a) Nyamakazi?
- b) Malungo?
- c) Edzi/ Kaliwondewonde/ Ulwele waboma?
- d) Komala?
- e) Usawi/ kuloga?

2 Please tell me what you know (in terms of causes, effects, if any, of:

- a) Rheumatism (nyamakazi)?
- b) Malaria (Malungo)?
- c) HIV/AIDS (Edzi)?
- d) Fortification (Kukhwima)?
- e) Witchcraft (Ufiti/kulodza or kulodzedwa)?

2 Chonde tandiuzani zimene mukudziwa inu kuti nthenda kapena zinazi zimayamba bwanji, zimayenda bwanji, ndiponso zimatha bwanji?

- a) Nyamakazi
- b) Malungo
- c) Edzi
- d) Kukhwima
- e) Ufiti

2 Komboleka kunsalila yayimanyi kuti indu ayi ikusatandaga uli, nambi ikusatendesya chichi/ikusawaga ni ligongo lantuli ku chilu chamundu?

- a) Nyamakazi?
- b) Malungo?
- c) Edzi/ Kaliwondewonde/ Ulwele waboma?

- d) Komala?
e) Usawi/ kuloga?
- 3 In your opinion, in the community, what is the prevention or treatment of
a) Rheumatism (nyamakazi)?
b) Malaria (Malungo)?
c) HIV/AIDS (Edzi)?
d) Witchcraft (Ufiti/kulodza or kulodzedwa)?
- 3 Mmene mukuganiza inuyo, m'mene timakhaliramumu, kaya kumudzi ngakhale kutauni, kodi chitetezo ndi kuchiritsa kwa izi ndi chiani?
a) nyamakazi
b) Malungo
c) Edzi
d) Ufiti
- 3 Ani indu yeleyi nikuilewaga chantuli, nambi mtela wakwe nichi?
a) Nyamakazi?
b) Malungo?
c) Edzi/ Kaliwondewonde/ Ulwele waboma?
d) Usawi/ kuloga?
- 4 What is your preferred prevention or treatment for:
a) Rheumatism (nyamakazi)?
b) Malaria (Malungo)?
c) HIV/AIDS (Edzi)?
d) Witchcraft (Ufiti/kulodza or kulodzedwa)?
- 4 Inuyo, makamaka pa nkhani zimenezi, chitetezo ndi kuchiritsa kumene mungafune nkotani?
a) Nyamakazi
b) Malungo
c) Edzi
d) Ufiti
- 4 Walakwe akusakamuchisyaga mtelachi ili yasumene yele induyi?
(mtela wakusaukulupililaga m'nope)
a) Nyamakazi?
b) Malungo?
c) Edzi/ Kaliwondewonde/ Ulwele waboma?
d) Usawi/ kuloga?
- 5 Do you believe that the following can be treated by traditional doctors?
a) Rheumatism (nyamakazi)?
b) Malaria (Malungo)?
c) HIV/AIDS (Edzi)?
d) Fortification
e) Witchcraft
- 5 Kodi muganiza kuti ntenda izi, kapena zinthu izi, zingachiritsidwe kapena kukonzedwa ndi mankhwala?
a sin'ganga akumudzi?
a) Nyamakazi)?
b) Malungo)?
c) Edzi)?
d) Kukhwima)?
e) Witchcraft (Ufiti/kulodza or kulodzedwa)?
- 5 Ana akusaulupililaga kuti yeleyi komboleka kupola ni mtela waisamba/wachiboyi?
a) Nyamakazi?
b) Malungo
c) Edzi (Kaliwondewonde, Ulwele waboma) komboleka kupola?
d) Komala kukusatetezyaga ku ilwele?
e) Usawi upali/ wandu akusaloganaga?

- 6 Do you think that the following can be caused by witchcraft?
 a) Rheumatism (nyamakazi)?
 b) Malaria (Malungo)?
 c) HIV/AIDS (Edzi)?
- 6 Kodi muganiza kuti ufiti ungabweretse izi?
 a) Nyamakazi
 b) Malungo
 c) Edzi
- 6 Mundu mpaka akulojye kuti ukole
 a) Nyamakazi
 b) Malungo
 c) Edzi/ Kaliwondewonde/ Ulwele waboma?
- 7 Do you think that the following can be cured?
 a) Rheumatism
 b) Malaria
 c) HIV/AIDS
- 7 Kodi mukuganiza kuti izi zikhoza kuchiritsidwa?
 a) Nyamakazi
 b) Malungo
 c) Edzi
- 7 Ana akusapililaga kuti indu yeleyi komboleka kupola?
 a) Nyamakazi
 b) Malungo
 c) Edzi/ Kaliwondewonde/ Ulwele waboma?
- 8 Do you think that fortification can protect you from the following
 a) Rheumatism (nyamakazi)?
 b) Malaria (Malungo)?
 c) HIV/AIDS (Edzi)?
 d) Witchcraft
- 8 Kodi kukhwima kukhoza kukutetezana kwa zinthu izi?
 a) Nyamakazi)?
 b) Malungo)?
 c) Edzi)?
 d) Ufiti/kulodza or kulodzedwa)?
- 8 Ana akusapililaga kuti komala kukusatetezyaga ku ilwele?
 a) Nyamakazi
 b) Malungo
 c) Edzi/ Kaliwondewonde/ Ulwele waboma?
- 9 Do you believe that witchcraft can cause
 a) Rheumatism (nyamakazi)?
 b) Malaria (Malungo)?
 c) HIV/AIDS (Edzi)?
- 9 Kodi ufiti ukhoza kuyambitsa
 a) Nyamakazi)?
 b) Malungo)?
 c) Edzi)?
- 9 Ana akusapililaga kuti Mundu mpaka akulojye kuti ukole
 a) Nyamakazi
 b) malungo/ malungo
 c) Edzi
 d) Komala kukusatetezyaga ku ilwele?

Notes: